A HISTORY OF SEXUAL ABUSE IN A SAMPLE OF WOMEN WITH EATING DISORDERS

by

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ABSTRACT

This study examines the incidence of a traumatic or abusive sexual experience in the lives of persons with eating disorders. Twenty-three eating disorder support group participants and 49 reference group participants completed the Eating Disorder Inventory (EDI) and a Sexual History Questionnaire (SHQ). The reference group was divided into high scoring and low scoring groups. The results showed that 74% of the participants in the eating disorder support group had experienced a history of childhood sexual abuse and/or traumatic sexual events, while the low scoring reference group reported that 44% of the women participating had experienced a history of childhood sexual abuse (CSA) and/or traumatic sexual experiences (TSE). A chi-square analysis revealed significant association between eating disorders (eating disorder support group versus the low scoring reference group) and a history of CSA and /or TSE ($p < .05$). An ANOVA on the entire data set between No and Yes categories (No history of CSA and/or TSE, and Yes, a history of CSA and/or TSE), showed that the EDI subscales of Drive for Thinness, Ineffectiveness, and Interoceptive Awareness were statistically significant in distinguishing the Yes from the No participants.

In addition, ten professionals involved in the areas of eating disorders or sexual abuse were interviewed to determine their clinical impressions about the relationship between sexual abuse and eating disorders. Themes which

emerged from their interviews indicated that eating disorders and sexual abuse often occurred together; and that low self-esteem and a poor body image often arise for eating disorder clients where there has been a history of sexual abuse. Eating disorders were viewed as the acting-out of a self-abusive pattern associated with early childhood trauma.

Conclusions and recommendations for future research and implications for counsellors working with eating disorders and sexual abuse are discussed. These implications include: failure of the DSM-III-R to guide clinicians in the spectrum of eating disordered behaviors and sociocultural variables, the value of an addiction framework in viewing treatment, and the importance of understanding the indicators of a history of sexual abuse and how they emerge.

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FOREWORD

Whenever I have conducted a workshop on body image, including research on eating disorders, I have included the following quote by Elisabeth Kubler-Ross:

> When human beings understand their place in the universe, they will become able to grow to assume that place. But the answer is not in the words on this page. The answer lies within you. You can become a channel and a great source of inner strength. But you must give up everything in order to gain everything. What must you give up? All that is not truly you; all that you have chosen without choosing and value without evaluating, accepting because of someone else's extrinsic judgement, rather than your own; all your self doubt that keeps you from trusting and loving yourself or other human beings. What will you gain? Only your own true self; a self who is at peace, who is able to truly love and be loved, and who understands who and what (s)he is meant for. But you can be yourself only if you are no one else. You must give up "their" approval, whoever "they" are, and look to yourself for evaluation of success and failure, in terms of your own level of aspiration that is consistent with your values. Nothing is simpler and nothing is more difficult (Kubler-Ross,1973, p.165)

I'm always surprised when someone asks 'what is the signifcance of this quote? ' For those who scratch their heads and find it without context, I explain that there was a time in my life when I was struggling to let go of my own preoccupation with weight. At that time, I was entering nursing school and in my first term, a classmate I admired for her confidence, ability, and sense of humor, was severely burned and suddenly died. Rosemary lived three months in a body that had 90% of its skin surface burned. My own preoccupation with my skin surface was reframed with Rosemary's loss. When I returned to the practicum placement we had

shared, I synchronistically found these words. This critical life event and the quote heralded a turning point in my own awareness of life, death, and how our creative energy can be lost in painful preoccupations. This quote and the event spoke directly to me about my ability to love, to love Rosemary, to love myself, and to love the gift of my own unique body.

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The Committee: Rey, Don, and Isobel. And Anne, a ghost member on this commitee, who is a faculty guardian angel in times of stress.

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My Surrogate Family: Frances Witt, Skye Raffard, Rosemary Simpson, Doug Graham, Dall Little and Brian Witt.

Greg Buhman: my friend and lifelong connection with Tom and Juli.

To each of you, I want to express my love and gratitude for being so patient and supportive. Knowing each one of you is a gift.

Especially to Mom and Dad, Pauline and Orv Lavell, it's been your love that encouraged risk-taking, creativity, a sense of humor, trust in myself, and a daughter dedicated to supporting you in your old age. Enmeshed or what?!!

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CHAPTER 1

Introduction

In the past fifteen years there has been an explosion of research in the area of eating disorders. Although the role sexuality plays in eating disorders has been identified by Bruch (1973), Crisp (1980), Woodman (1980), the relationship between sexual abuse and eating disorders has received comparatively little attention. Eating disorders have been generally conceptualized as a spectrum of behaviours with a multi-dimensional framework of contributing factors and treatment modalities (Andersen, 1983; Brownell & Foreyt, 1986; Garfinkel & Garner, 1982; Garner, Olmsted, & Polivy, 1984). Recently, however, sexual abuse as a concomitant factor has received attention as a research focus. Oppenheimer, Howells, Palmerr and Chaloner (1985) systematically asked 78 eating disordered patients about any history of adverse sexual experiences, and a surprising two thirds revealed having had such a history. Kearney-Cooke (1986) sampled bulimic women and found that 66% reported some form of physical or sexual abuse. These two studies are supported by a number of case history reports, which describe the development of eating disorders with a history of sexual abuse in childhood, incest, rape or sexual assault (Andersen, 1986; Goldfarb, 1987; Hambidge, 1988; Schecter, Schwartz, & Greenfeld, 1987; Sloan & Leichner, 1986). Most recently, Smolak, Levine and Sullins (1990) found that: sexually abused respondents scored higher than

non-abused respondents on the Eating Disorder Inventory. However, Coovert, Kinder and Thompson (1989) reviewed the research on anorexia nervosa and bulimia nervosa in about thirty studies, and were unable to find a consistent incidence of sexual abuse among anorexic or bulimic clients.

According to a report commissioned by the Canadian Government (Report of the Committee on Sexual Offences Against Children and Youths, 1984), at sometime in their lives, about one in two females and one in three males have been victims of unwanted sexual acts. Four in five of these incidents first happened to these persons when they were children or youths. This report is based on the National Population Survey which drew upon the experiences of 2008 people, age 18 and older, from all regions of Canada. This indication of high base rates of both eating disorders and sexual abuse in the general population supports the need to understand the dynamics of each and the areas of possible overlap.

Many clinicians and researchers of sexual abuse identify eating disorders as occurring after a history of child sexual abuse or incest (Andersen, 1986; Finkelhor, 1986; Goldfarb, 1987; Kearney-Cooke, 1986; Maltz & Holman, 1987; Meiselman, 1984; Oppenheimer et al, 1985; Schecter, Schwartz, & Greenfeld, 1987; Sloan & Leichner, 1986), Yet other studies (Coovert, Kinder, Thompson, 1989; Finn, Hartman, Leon, Lawson, 1986) conclude that there is meagre support for a relationship between sexual abuse and eating disorders.

There may be several reasons for these contradictions. First,

problems of definition have resulted in a lack of consistent data regarding base rates of both eating disorders and sexual abuse in the normal population. Second, sexual abuse was often not even considered as a variable in much of the research reviewed. So perhaps because sexuality was mentioned the assumption was made that a thorough sexual history was a part of the studies reviewed. Third, a lack of knowledge of how to gather data concerning sexual abuse and the characteristic difficulties of recalling such events make this type of inquiry less attractive to researchers. Fourth, methodologies which emphasize impersonal data collection lack the on-going kind of rapport and trust to gain accurate information. Finally, the legal , ethical and reporting implications of acquiring the knowledge of child sexual abuse and the possibility that other children are still at risk may be enough to minimize research interest. Consequently, current research consists largely of practitioner's anecdotal findings, case histories and a few clinical samples without normal control groups. More work is needed in assessing the occurrence of eating disorders and sexual abuse within a comparison group design. Further validation of base rates of eating disorders and sexual abuse in normal and clinical population is also needed. Group design may allow for identification of patterns and variables which do not emerge with anecdotes and case histories.

The interaction between sexual abuse and/or sexually traumatic events and eating disorders is not clear. The purpose of this research is to compare the incidence of a history of sexual abuse in a sample of women with eating diosrders

with a sample of women who do not have eating disorders using the Sexual History Questionnaire (SHQ) and the Eating Disorder Inventory (EDI).

In addition, a pilot study surveyed clinicians and researchers about their perceptions and experiences with eating disorders and sexual abused clients; specifically to what extent do clinicians and researchers identify a connection between eating disorders and sexual abuse? What variables do professionals identify as key to the genesis of these two problems occurring together?

If, as asserted by Goldfarb (1987), eating disordered behavior develops in concert with sexual trauma or chronic abuse, then eating disorders may make an even more striking resurgence in times of developmental stress. Even more problematic for counsellors is what appears to be the exclusive attention given to either an eating disorder history or a sexual abuse history. This singular focus may interfere with a counsellor's ability to understand the context, meaning and life history of the client. Overlooking either problem could lead to unrecognized sources of pain or grief, inadvertently supporting socially approved methods of raising self esteem such as dieting, and ultimately delaying the client's recovery process.

Assumptions and Limitations

Several assumptions underlie this study. Eating disorders and sexual abuse trauma are not entirely women's issues; incest and sexual abuse occur in males as well as females (Muni-Brander & Lachenmeyer, 1986). Body image is

a prevalent concern for many people but the issues of male adjustment to sexual abuse or the occurrence of eating disorders in males will not be addressed in this work. This does not preclude their importance as sexuality, body image and coping with negative life events are inherent to the human condition.

Another assumption relates to the well documented complexity of eating disorders, their etiological factors and multidimensional aspects and impact. The intention of focusing on sexual abuse in this study is simply to explore one area of possible influence and does not infer causality in relation to eating disorders. The literature provides many possible points of articulation or overlap including such variables as family factors, masked presentations, and aspects of the addictive nature of eating disorders, that are not addressed in this study.

Chapter 2

Review of the Literature

Current literature linking eating disorders and sexual abuse seems to indicate that an overlap exits (Andersen, 1986; Goldfarb, 1987; Hambidge, 1988; Oppenheimer, 1985; Kearney-Cooke, 1986; Schecter, Schwartz, & Greenfeld, 1987; Sloan & Leichner, 1986). Several dimensions indicative of the concatenation between these two areas have emerged. Conceptually these themes could be regarded as understanding eating disorders within a continuum including weight preoccupation and compulsive overeating; the addictive nature of eating disorders; the masked presentations of sexual abuse; risk factors in dysfunctional families; and body image, sexuality and shame. As yet, the pathway between eating disorders and sexual abuse remains unclear.

Recent Literature Linking Sexual Abuse and Eating Disorders

Incest survivors often find their way to therapy or medical help through what Gelinas (1983) called disguised presentations. Problems such as drug and alcohol dependency, relationship issues or sleeping disorders have often been described as the presenting complaint (Finkelhor, 1984; Hunter, Kilstrom, & Loda, 1985; Maltz & Holman, 1987; Meiselman, 1984). Eating disorders have been identified as another common behavioral manifestation of the impact of child sexual abuse by Maltz & Holman (1987) Meiselman (1984) and Finkelhor (1984). However, the research to support these claims is scant. It appears that what many notable practitioners and researchers see as a link between these two client populations is

not well supported by current research.

Even so, sexual conflict in individuals experiencing eating disorders is well documented (Bruch, 1973, 1978; Crisp, 1980; Boskind-Lodahl, 1976). Oppenheimer, Howells, Palmer, & Chaloner (1985) and Kearney-Cooke (1986) each found that two thirds of their eating disordered patients described a history of adverse sexual experience. Since then most reports have been anecdotal or case histories. Andersen (1986) postulated that eating disorders may serve as a coping mechanism for a traumatic sexual event, such as rape or incest. Sloan and Leichner (1986) described five case histories where a history of sexual abuse or incest was revealed in patients being treated for eating disorders. In each case, the history of sexual abuse or incest was reported not at first contact, but after several months of treatment. Goldfarb (1987) also reported three case histories where sexual abuse was antecedent to anorexia nervosa, bulimia and compulsive overeating. Both authors stressed the importance of determining the presence of a history of sexual abuse, in order to fully understand the dynamics and the course of treatment for persons with eating disorders.

Smolak, Levine and Sullins (1990) found that sexually abused respondents scored higher than non-abused respondents on the Eating Disorder Inventory, although a MANOVA on the EDI subscales in their study failed to reveal between-group differences; family factors appeared to play a role in the emergence of eating disordered attitudes and behaviours in women who were sexually abused as children.

In a letter published in the British Journal of Psychiatry, Hambidge (1988), testifies about the clinical relationship between sexual abuse and eating disorders:

> While every woman's story is unique, one particularly common sequence of events is difficult childhood, sexual assault in adolescence, teenage anorexia nervosa, followed by difficulties in adult sexual adjustment, often with chronic eating disorders. Over the past three months I have seen six women who presented with this personal history (Hambidge, 1988, p.145)

Eating Disorders : A Continuum of Coping

Although eating disordered behaviour has been observed for several centuries (Andersen, 1983), only recently has an attempt been made to classify the criteria for eating disorders. In the revised Third Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R) published by the American Psychiatric Association, a list of criteria for diagnosis of anorexia nervosa, bulimia nervosa, pica and rumination disorder of infancy has been included. Obesity is considered a physical disorder, unless there is evidence that psychological factors are important in the etiology, in which case it is classified under Psychological Factors Affecting Physical Condition. Also included in the DSM-III-R is a category called Eating Disorder Not Otherwise Specified, which gives three examples of eating disordered behaviour that do not meet the specific requirements of the other classifications. This category may be referred to as atypical eating disorder (Herman & Polivy, 1987). The purpose of such criteria has been to offer guidelines in making medical diagnoses and to aid research efforts. An important assumption of this study is that eating

disorders exist on a continuum, not in discrete categories as inferred by the DSM-III-R (1987) classifications.

In contrast, there are many researchers and practitioners who support a spectrum of eating disorders, including anorexia nervosa, bulimia and obesity (see Appendix A for a definition of these terms) (Andersen, 1983; Bruch, 1981; Foreyt, 1987; Goode, 1985; Smead, 1983, 1984, 1985). In fact, chronic dieting and preoccupation with weight and body image can also be included in this spectrum. Herman and Polivy (1987) argue that the actual physiological and psychological effects of dieting and/or caloric restriction with the concomitant focus on body weight or image can perpetuate anorexia and bulimia (Herman & Polivy, 1987; Smead, 1984). Smead (1983) underscores the point that labels may obscure the similarities of persons assigned to different categories and that labels may obscure similarities between labelled individuals and those not so labelled such as "normal" dieters.

Smith (1981) reviewed the DSM-III system of classification and its social and professional implications in regard to the therapist client relationship as well as the issues of informed consent, confidentiality and freedom of choice. He warned against placing biblical qualities on a manuscript designed to organize information. Smith points to the fact that the DSM-III system of classification shows a near total neglect of socio-cultural and social psychological variables. As well, the whole area of family functioning is overlooked in this system of classification. According to Shisslak and Crago (1987) in their examination of prevention of eating disorders, the most salient risk factors identified thus far have been sex, age, social

class, personality structure, family dynamics, constitutional predisposition, sociocultural pressures and excessive dieting. The widespread promotion of thinness and dieting in our culture certainly needs to be addressed when hoping to understand the dynamics of eating disorders. Table 1 highlights a continuum of eating disorders which gives some idea of the scope of eating behaviors as they relate to each other along a continuum of weight preoccupation and control methods. Implied within this continuum is the notion of movement from one set of behaviors to another with some overlap.

Table 1

A Continuum of Eating Disorders

The Individual:		
anorexia nervosa	bulimia chronic dieting	compulsive overeating/obesity
.....weight preoccupation.....		
excessive control	misc. methods of weight control	abandonment of control

Based on the DSM-III (1980) criteria, Finn, Hartman, Leon & Lawson (1986) reported a lack of confirmation for a clinical hypothesis between eating disorders and sexual abuse. Even the criteria in the revised edition of the DSM-III are not

developed enough to delineate a list of what is considered atypical eating disordered behaviour (only three examples). Their study reported that of a sample of 87 women, with a history of sexual abuse and receiving group psychotherapy, that 21% were bulimic, 1% anorexic and that 82% of all participants reported at least moderately abnormal eating patterns. The "less severe forms of eating disturbances that did not meet the DSM-III criteria" (Finn et al., 1986) included:

- binge eating (defined as the periodic consumption of 4000 calories in 2 hours or less
- the use of self-induced vomiting, laxatives, or enemas as a method of weight control
- the regular use of weight reducing medications
- severely restrictive dieting (defined as consuming 1000 or less calories per day)

If the incidence of eating disorders is significantly higher in a population of women with a history of sexual abuse, then practitioners and clients need to be aware and informed so that appropriate treatment issues can be addressed. The problem of DSM-III-R classification is only a problem for those who adhere to the criteria rigidly. DSM-III-R is a reference manual with a condensed view of each disorder. It does not describe the entire picture of each disorder nor of any individual client.

Eating Disorders: Control and Addiction

One way of conceptualizing the dynamics of eating disorders is through an

addiction model, where attempts at controlling of feeding one's body take on compulsive characteristics. The misuses of food and dieting may be demonstrated in the anorexic individual striving for effectiveness and self-esteem through thinness or in the compulsive overeater's need to self-nurture or insulate oneself. Addictive behaviours have been identified as inappropriate ways of meeting needs such as relaxation, stress management, or in coping with painful life experiences (Bradshaw, 1988; Schaef, 1987).

According to Schaef (1987), addiction is any process over which we feel powerless. She divides addictions into two categories: substance addictions (such as alcohol, drugs, nicotine, caffeine, food) and process addictions (such as accumulating money, gambling, sex, work, religion, worry). The word addiction comes from the Latin addicere, to give oneself up. Bradshaw (1988) says that to be addicted one has to give oneself up to something obsessively, surrender to some perceived means of control (ie. the addiction) with a concomitant sense of powerlessness.

Accordingly, Bradshaw proposes that it is necessary to be aware of powerlessness and unmanageability, in the face of addictions. Trying to control an addiction is a contradiction of terms. Paradoxically, it is ultimately the process of surrender, or facing that one is unable to control the addiction, that brings healing. The success of "twelve step programs" (ie. Alcoholics Anonymous, Overeaters Anonymous) and the emphasis on spiritual surrender is testimony to this point.

> An addiction keeps us unaware of what is going on inside us. We do not have to deal with our anger, pain, depression, confusion, or even our joy and love, because

> we do not feel them, or we feel them only vaguely. We stop relying on our knowledge and our senses and start relying on our confused perceptions to tell us what we know and sense. In time, this lack of internal awareness deadens our internal processes, which in turn allows us to remain addicted. (Schaef, 1987, p.18)

With respect to eating disorders, food can be considered an abusable substance (Bradshaw, 1988; Chelton & Bonney, 1987; Cook, 1987; DiClemente, 1986; Janas, 1987; Katz, 1985; Peele, 1985; Schaef, 1987). Food, however, is essential to life and "use" cannot be discontinued as a simple means of recovery. As Schaef wisely points out, one can be addicted to eating (obesity) or not eating (anorexia nervosa).

Recently, Vandereycken (1990) wrote a cautionary article on the risks of over generalization and selective reduction in using the addiction analogy with eating disorders. He does support the analogy as a" valuable inspiration" for a therapist as one approach to a complex problem. In conclusion he states: "We must avoid the procrustean beds of diagnostic uniformity, interpretive simplicity, and therapeutic orthodoxy" (1990, p.99).

Bulimia can represent the fulfilling of an addictive need to eat followed by a weight control mechanism (purging, by vomiting, the use of laxatives, or epicac, etc.). The "high" that anorectics experience, a sense of elation, have also been speculated to be promoted by an elevated endorphin level (Katz, 1985). The drive to recapture this high, plus the sense of personal control and efficacy gained by "controlling" one's body, fuels continued dieting despite growing emaciation, thereby sustaining malnutrition in an addictively vicious circle.

But the sense of self-efficacy generated by dieting is seductive and ultimately pathological in its generation of a weight preoccupied mind set (DiClemente, 1986; Polivy & Herman, 1987). In their discussion of "normal" eating, Polivy & Herman (1987) acknowledge that the dieter fears allowing herself to eat naturally, expecting uncontrollable eating and weight gain. It is dieting itself which produces these fears (Polivy & Herman, 1985), through the physiological and psychological effects of starvation or restricted eating behaviours. Ciliska (1986) in a recent study, found that truly uninhibited eating, that is responsive to satiety cues, does not lead to overeating or binging. In fact people often lose weight by abandoning their diets (Polivy & Herman, 1983). Two weeks of restrictive eating can lower the basal metabolic rate by as much as 30 percent, making "dieting" a self-defeating behaviour. Learning to trust the wisdom of the body and relinquishing the "control" offered by dieting to the sensitivity to hunger and satiety cues, should be a major dynamic in the treatment of eating disorders.

Another feature of the addiction framework that fits well with eating disorders is the idea of seeking magical solutions to life's problems (Bradshaw, 1988; Janas, 1987; Peele, 1985). In eating disorders dieting is the magical solution that offers self-esteem, a sense of control over one's life, and often social approval based on the general societal value of thinness. The idea of pursuing magical solutions refers to a mind set where there is a fear of failure, and a preference to easy and quick solutions versus addressing the roots of a problem. Food, drugs, alcohol, or powerful experiences can provide the temporary modification of

troubled feelings and sensations without addressing the actual causes (Peele, 1985). Described within the Table 2 are the social features supporting eating disorders as addictive behaviors, as well as individual traits and needs, predominant vaues and the temporal dimension of developmental changes and/.or traumatic events which influence the onset and perpetuation of these behaviors.

Table 2 (Based on Peele, 1985)
Aspects Creating An Addictive Need in Eating Disorders

Social Milieu:
- prescribes values that are difficult to attain
- environment perceived as stressful, uncontrollable
- changing gender roles
- general discomfort with acknowledging sexuality
- pervasive devaluing of feminine roles
- media representation of what is beautiful too narrow
- a low value on aging and concomitant sagging bodies

Individual Traits and Needs:
- high fear of failure
- intolerance of uncertainty
- low self-esteem
- low self-efficacy
- fear of fat or self-loathing due to perception of being fat
- low expression of anger
- high need to please others
- a sense of being able to deal with life indirectly through food or the lack of food

Values and Outlook:
- values highly externally referent
- an almost brainwashed belief in the value of thinness (anorexia - weight preoccupied and bulimia)
- a sense of giving up or giving in to a quick fix for nurturing or dealing with anxiety, through food (obesity)
- belief in the magical solution of dieting or other methods of losing or controlling weight

The Temporal Dimension:
- maturational development, ie. physiological emergence of secondary sex characteristics, psychological process of individuation
- life-span and situational variables, ie. changing social values of beauty, experience of a traumatic event

Using food to satisfy hunger and to self nurture is healthy. Woodman (1980) describes data from a study of obese women where food becomes the focus for depression, repressed anger, anxiety, and for repressed sexuality. Food can become the focus for controlling one's fate or expressing defiance. When food or the lack of food becomes the magical solution, one stops listening to mind-body hunger and satiety cues, and what results is anything along the eating disorder continuum, from anorexia nervosa, bulimia nervosa, preoccupation with weight, chronic dieting or obesity/compulsive overeating.

Bruch (1981) and Woodman (1980) agree that there is substantial similarity between obese individuals and those with anorexia nervosa. Tables 3 and 4 list some common and contrasting factors between anorexia and obesity/compulsive overeating which justify the concept of a continuum of eating disorders. Basseches & Karp (1984) support the similarities in their study, finding significant similarities on a measure of field dependence between anorexic and obese individuals. The dynamics of addiction as described by Schaef earlier, as a lack of internal awareness, match the essential features of eating disorders as outlined by Bruch and Woodman. Addictive behaviours can also be described in terms of locus of control or reference (Peele, 1985; Schaef, 1986). Being externally referent, or having an external locus of control are features of addiction and co-dependence (Peele, 1985; Schaef, 1985, 1986). Certainly with eating disorders and the "relentless pursuit of thinness" there is an implication of being externally referent in values and self-esteem.

Table 3

Common Factors Between Anorexia and Obesity

- basic disturbance in self-awareness and body awareness

- inability to recognize hunger and other body sensations

- distorted awareness of body image

- food problems probably began with a maturational of situational event

- repression of sexuality

- repressed emotions, too compliant, too desirous to fulfill parents' unlived lives

- unable to live her own life due to unawareness of her own feelings and feminine needs

- attempt to gain control over her own life through eating or refusing to eat

- believes cultural fantasy that thinness will solve her problems

- weak ego, basic self-deception; danger of psychotic break

- desire to be perfect counterbalanced by sense of inner worthlessness

- death wish compensated by fierce desire for life

- overwhelming sense of aloneness

- history of alcoholism in the family (Andersen, 1986)

Note: Based on Woodman, 1980

Table 4

Contrasting Factors Between Anorexia and Obesity

ANOREXIA	OBESITY
- terror of being fat	- terror of being fat equals terror of deprivation
- tends to become rebellious and stubborn	- tends to remain outwardly compliant
- feels acceptable in culture; wins admiration through losing weight at first	- considers herself ugly, cowardly failure in eyes of parents and peers
- happy in moral strength to stay with diet	- develops sense of moral inferiority
- cyclic starvation, binging and ritual vomiting	- cyclic dieting, starvation, binging
- attempts to put fantasies to the test by dieting	- refuses to put fantasies to test; believes everything could still be right if she were thin
-preoccupation with Light (Jungian concept)	- preoccupation with Darkness (Jungian concept)

Note: Based on Woodman, 1980

Once the behaviours of anorexia nervosa, bulimia and compulsive overeating have been well entrenched, they "take on a life of their own" according to those experiencing them, and can seem out of the individuals control. With the obsessive drive for control or thinness, comes compulsiveness or a perceived lack of control. This is the nature of addictions and helps explain the futility of "controlling" an addiction, or the behaviours associated with them. Rigid adherence to DSM-III-R criteria, which lacks a sociocultural perspective on addictive behavors, may influence practitioners in overlooking the risk behaviors which may promote eating disordered behavior and limit researchers attempts to define the scope of the problem.

Sexual Abuse: Trauma and Trigger

The study of childhood sexual abuse and/or incest is a study of the impact of a traumatic experience, or experiences, and a developmental tragedy. Besides the identification and treatment of a child or adult who has experienced sexual abuse, the individual faces a complex crises that may see the disintegration of their family, imprisonment of an offender who may be both loved and hated, and possible court appearance. Certainly, the secret of sexual abuse can have profound impact on a child or adult.

Most studies of sexual abuse are retrospective, asking adult survivors of their childhood experiences. There appears to be a consistent picture of adult psychological problems correlated to childhood sexual abuse (Finkelhor, 1979; Meiselman, 1978; Sgroi, 1975). Child sexual abuse has been linked with depression, self destructive behaviors (suicide attempts and self-mutilation), anxiety and sleep disorders (anxiety attacks, nightmares, difficulty sleeping), sexual dysfunction, relationship problems, feelings of low self-esteem, isolation, stigmatization, drug and alcohol problems and more recently, eating disorders. Perfectionism is identified in a study of adolescent survival responses to incest (Lindberg & Distad; 1985) as one of many attempts to relieve stress or gain some sense of control.

Summit (1983) defines the Child Sexual Abuse Accommodation

Syndrome which consists of five categories of responses. These are secrecy, helplessness, entrapment and accommodation, conflicted disclosure and retraction when flooded by guilt, fear and feelings of betrayal and confusion. It is necessary to understand the issues of power and control that a child is faced with, and that if untreated become the dynamics of an adult belief system that interferes with a positive self image, body image, and relationships with others (Gil, 1988).

Gil (1988) describes intrapsychic defenses, interactional defense patterns and affective/expressive disorders that are the child's coping mechanisms in the face of sexual abuse. Intrapsychic defenses include denial, dissociation, physiologic defenses (i.e., anaesthesia through self hypnosis, self mutilation, and hyperalertness to even slight physical discomfort) and cognitive defenses (i.e., self blame and beliefs that they are bad or unworthy). Interactional defense patterns include aggression, avoidance (running away, withdrawal in a younger child, or over-compliance), acting-out behavior, provocative behavior (seeking negative attention), and sexualized behavior. Affective/expressive disorders appear in children who have learned that facial expressions or verbal expressions of feelings like fear, joy, anger or pleasure may provoke abuse. What results is expressionless or flat affect (Gil, 1988).

Hunter, Kilstrom and Loda (1985) discuss the "masked presentations" in medical settings of sexually abused children including genital infections, psychosomatic and behavioral disorders (i.e., anorexia, drug overdose,

enuresis, pregnancy related conditions), and symptoms of atypical or disseminated sexually transmitted disease (ie. joint pains and swelling, fever, lethargy and sore throat). Gelinas (1983) describes how incest survivors often find their way to therapy or medical help through disguised presentations . Again, problems such as drug and alcohol dependency, relationship issues or sleeping disorders may be the presenting complaint (Finkelhor, 1984; Hunter, Kilstrom, & Loda, 1985; Maltz & Holman, 1987; Meiselman, 1984). For example, Hunter, Kilstrom, and Loda (1985) studied 50 children whose initial presentations masked the presence of sexual abuse and compared them with 31 overt cases of sexual abuse. Their findings indicated that the masked group, who displayed a broad variety of symptomology (i.e., psychosomatic and behavioral problems, genital symptoms, pregnancy related conditions, symptoms of atypical or disseminated sexually tranmitted disease) were twice as likely as the overt group to have a chronic history of sexual abuse; that school problems and psychosomatic disorders were three times as frequent; and the offender was more often an immediate family member, usually the father. There are several unique features that develop in sexual abuse that deserve discussion in their interesting conceptual or semantic parallels to eating disorders.These are: dissociation, self-mutilation, post-traumatic stress disorder and blurred role boundaries.

Dissociation as defined by the DSM-III-R (1987) is "a disturbance or alteration in the normally integrative functions of identity, memory or

consciousness". It is an innovative defense against trauma (Gil, 1988). Not all survivors use dissociation, but it occurs when the abuse is chronic, unpredictable and overwhelming (Kluft, 1986). There are four types of dissociation identified: multiple personality disorder, psychogenic fugue, psychogenic amnesia, depersonalization disorder and a category of atypical dissociative states (DSM-III-R, 1987). A similar mind-body split with dissociative features has been identified in anorexia nervosa (Garfinkel & Garner, 1982).

Self-mutilation is the act of causing physical damage to ones' body which may be chronic, ritualistic or sporadic (Gil, 1988). Self-mutilation is linked to dissociation, in that the individual may have the perception of being outside ones' body, or in a bizarre way the pain created may be evidence of being alive. Or it can be a form of self-punishment. The parallels with some forms of dieting and extreme weight control methods is striking (ie. vomiting, purging with laxatives or epicac, chronic dieting and self-starvation as punishment for weight gain).

Again, the DSM-III-R criteria may be too rigid and may actually be describing a range of dissociative phenomena. Psychogenic amnesia and fugue, and depersonalization disorder, all have elements of dissociation and "an alteration in the perception or experience of the self in which the usual sense of one's own reality is temporarily lost or changed" (DSM-III-R, 1987).

Post-traumatic stress disorder (PTSD) has recently been linked with the women who have experienced childhood incest or sexual abuse (Gil, 1988;

Lindberg & Distad, 1985). Although first identified in the survivors of the Vietnam War (Janoof-Bulman, 1985), PTSD also "aptly describes the reactions of individuals who have experienced other traumatic events such as serious crimes (eg. rape and kidnapping), accidents (eg. car accidents with serious physical injury, airplane crashes), and disasters (eg. floods, large fires)". These events and the psychological distress created are outside the range of usual human experience DSM-III-R, 1987; Gil, 1988). Rossi (1986) in his book "The Psychobiology of Mind-Body Healing" gives a clear conceptual and research based description of how one dissociates in the face of trauma, through a kind of self-hypnosis. His framework sheds light on the development of amnesia in these disorders. Recent literature in eating disorders support the notion that they can be a response to traumatic events, such as rape or incest (Andersen, 1986).

Victimization is a key concept, where reactions include shock, confusion, helplessness, anxiety, fear and depression (Gil, 1988). PTSD explains the "flashback" phenomena and how certain events or experiences may act as triggers to recalling painful repressed memories. These overwhelming recollections may trigger coping mechanisms (i.e., addictions) in an attempt to control the pain, fear or terror as it is recalled.

The range of psychological and physiological sequelae is considerable.. From the literature, it is apparent that many coping mechanisms

fall into a category of self destructive behaviors, including addictions.

Family Dynamics and Developing Autonomy

The concept of family enmeshment is an important dynamic in dysfunctional families where either eating disorders or sexual abuse exist. Enmeshment refers to the boundaries of a dysfunctional family system where according to Minuchin (1974), a family develops it's own isolated microcosm in which autonomous functioning of family members decreases. He asserts that when there is a heightened sense of belonging in a family there is also a major yielding of autonomy. Behavior of one family member immediately affects others. The clarity of family boundaries is a useful parameter in assessing the family functioning of eating disordered and sexually abused clients.

Failure to individuate from an enmeshed and overprotective family has been cited by many notable practitioners and researchers (Bruch, 1973; Palazoli, 1978; Sours, 1974) as characteristic of the families of eating disordered clients. Although more research is needed in this area, Strober and Humphrey (1987) conclude from their review of the literature that the predisposition to eating disorders "may well originate in genetically influenced variations in personality and temperament, but their ultimate expression requires the added presence of disturbances in family interactions and in other sociocultural pressures"(p.657). Strober and Humphrey (1987) make three

observations in regard to families with eating disorders:

1. The family environment tends to hamper the development of a stable identity, of autonomy, and of self-efficacy through a cluster of disturbed patterns of relating and interacting that are characterized by enmeshment, poor conflict resolution, emotional over-involvement or detachment, and a lack of affection and empathy.
2. That a variety of family-related factors shape the phenomenology of eating disorders, especially bulimia, including poor self-regulation of affect and behavior, tendencies toward alcoholism and obesity, and family-wide discord and emotional deprivation.
3. That eating disorders tend to aggregate in famiies, although genetic and environmental contributions to transmission have not yet been elucidated.

John Bradshaw, in his widely-acclaimed book "Bradshaw on: The Family", describes the dynamics of dysfunctional families in the context of addictions, shame production and the multigenerational process by which families perpetuate rules and behaviour. He addresses both eating disorders and sexual abuse in this thesis.

The concept of blurred role boundaries helps explain the dynamics of interpersonal relationships and of ones' relationship to their own body following the experience of sexual abuse. According to Sgroi (1982) establishing and

enforcing role boundaries is a task of parenting, which when neglected can contribute to setting the stage for sexual abuse or incest.

> Child sexual abuse is disorienting because the victims frequently experience role confusion due to the inevitable blurring of role boundaries between the perpetrator and the child. For an adult who occupies a power position to turn to a relatively powerless child for a sexual relationship implies a profound disregard for the usual societal role boundaries (Sgroi, 1982, p.123).

The child's sexuality and sense of self are greatly impacted by such role and boundary confusion. Later awareness of the mismatch between experience and social values or roles can produce incapacitating shame and a sense of stigma in the survivor. Our self-identity and our relationship with the world is mediated by our bodies, as is described in the literature on body image and development (Brown, 1977; Fisher, 1986).

Table 5

The Process of Autonomy in Relation to Eating Disorders

- trust the mind/body's inner wisdom
- experience a surrender and letting go of "control"
- be responsive to hunger and satiety cues
- be responsive to physical, psychological and spiritual needs
- examine personal values in relation to social values
- look for those values which you have "chosen without choosing" and "value without evaluating".
- seek help and resources when feeling "stuck"
- understanding basic knowledge of nutrition

Autonomy is an important concept to understanding clients with eating disorders, those who have been sexually abused, and those who have both problems. Table 5 describes from my own experience and study the necessary elements in discovering a sense of personal autonomy versus "control". This list is reinforced by the following quote from Marion Woodman (1980, p.67):

> Any woman who takes herself seriously must accept the responsibility of knowing and loving her body....Only when she can consciously recognize her emotions and can begin to deal with life directly will her reactions cease to appear in physical form as a symptom.
>
> Certainly, some awareness of the complexity of the biochemical reactions in her body in response to her own emotions, conscious and unconscious, will bring her to to an appreciation of this magnificent creation. She may learn to listen to its wisdom. This is her body. This is her greatest gift, pregnant with information she has refused to acknowledge, grief she thought she had forgotten, and joy she has never known. If she can love her own 'massa confusa' and dedicate herself to its mystery, she may one day find herself smiling from her mirror.

Viewing eating disorders on a broad continuum of behaviors and within an addiction framework, has many implications for the treatment of individuals struggling with these problems, and especially for those whose eating disorders may be linked to sexual abuse.

A landmark study by Werner (1989) may provide some clues as to why

some people survive dysfunctional backgrounds while others do not. In a study that spanned over thirty years she and her colleagues assessed the long term consequences of prenatal and perinatal stress, and documented the effects of adverse early rearing conditions on children's physical, cognitive and psychosocial development. In a relatively stable population that began with 698 infants in 1955 and ended with 545 individuals in 1985, they found many interesting themes. Two hundred and one children were designated as high-risk or "vulnerable" due to experiencing moderate to severe perinatal stress, growing up in poverty, being reared by parents with no more than eight grades of formal education, or having lived in a family environment troubled by discord, divorce, parental alcoholism or mental illness. They found that 72 of the 201 individuals grew into competent young adults who loved well, worked well and played well. This group was termed "resilient". A number of protective factors were identified with the resilient group that related to factors in the families, outside the family and within the resilient children themselves; these included:

- characteristics of temperament , including active, easygoing, affectionate
- a tendency to seek out novel experiences and ask for help when needed
- resilient children tended to come from families having four or fewer children
- they had the opportunity to establish a close bond with at least one caretaker from whom they received positive attention in the first years of life
- were particulary adept at recruiting surrogate parents when biological

parents were unavailable or incapacitated

- found a great deal of emotional support outside their immediate family, including close friends
- they had often adopted a favorite teacher or role model
- with the help of these support networks, they developed a sense of meaning in their lives, an attitude of confidence and hopefulness

In summary, Werner states that:

> "...in an individual's development from birth to maturity, there is a shifting balance between stressful events that heighten vulnerability and protective factors that enhance resilience.
>
> As long as the balance between stressful life events and protective factors is favorable, successful adaptation is possible. When stressful events outweigh the protective factors, however, even the most resilient child can have problems. It may be possible to shift the balance from vulnerability to resilience through intervention, either by decreasing exposure to risk factors or stressful events or by increasing the number of protective factors and sources of support that are available (1989, p.111).

Although this study did not address eating disorders or sexual abuse, this researcher believes that the same factors which created resiliency in this population, may be significant variables in determining who develops an eating disorder after a history of sexual abuse or trauma.

The following section describes aspects of body image and sexuality which may shed light on the how eating disorders may become a coping mechanism for many sexually abused individuals.

Body Image and Sexuality: An Identifiable Link?

Very little has been written on the subject of normal or healthy sexuality (Gil, 1988; Sgroi, Bunk & Wabrek, 1988). More has been written on the normal development of body image (Brown, 1977; Fisher, 1986). Much of what is known in both these areas is derived from the study of pathology. This review of literature has been a cursory glance at several complex "pathological" problems which many women and men struggle with in our culture.

After a review of addictions and the dynamics of eating disorders and sexual abuse, one may conclude that we are dealing with complex individual, family and social problems that often express themseves in unique ways in the female body, with mental and spiritual scarring.

Issues of power and control surface in sexual abuse and, in a different way, in eating disorders. The dissociation occurring in a sexually abused client is a result of a traumatic event or events. The mind-body split is identified as a struggle for control in an eating disordered client. As well, the body image distortions experienced in eating disorders have a dissociative quality, where the mind still sees fat when the body is emaciated. The trauma inflicted on the body through the practice of certain eating disorder behaviors can be likened to a form of self-mutilation (Kearney-Cooke, 1988). Purging behaviors can be seen as a form of punishment after a gluttonous feed.

Exploring the dynamics of shame and body iimage can provide intervention strategies for the therapist and new variables to explore for the researcher.

In a wonderful book, based on their experiences as therapists, Mcfarland and Baker-Baumann (1990) state:

> The female body has become a scapegoat for the culture's shame about its feminine side. This shame has manifested itself in the American woman's obsession with diet, with exercise and even with having surgery so that her body can be an object of pride and measure up to the cultural ideal of beauty and femininity.
>
> Many women are able to withstand these pressures and maintain a more nurturing and realistic relationship with their bodies. However, there are women, expecially those from dysfunctional families, who have a disturbed body image as well as a disturbed relationship with food. An early family history of shaming makes a woman more vulnerable to the cultural dictate of feminine beauty and acceptability as a measure of value and self-worth. These are the women who are prone to develop an addictive relationship with food in order to hide the deeper wounds of their personal shame.

Tables 6 & 7 summarize similarities and differences between eating disorders and sexual abuse with table 6 providing citations based on this review of the literature.

Table 6

Some Similar Features of Sexual Abuse and Eating Disorders

Feature	References
- issues of power and control evident	Brown, 1985; Orbach, 1978; Sgroi, 1982
- addictive behaviors common in both families	Bradshaw, 1988; Schaef, 1987
-blurred role boundaries or enmeshment in family functioning	Minuchin, 1974; Sgroi, 1982
- an element of secrecy, or a secret life with a public self and a private self	Bradshaw, 1988; Bruch, 1978; Kearney-Cooke, 1988
- an element of shame and guilt	Bradshaw, 1988; Finkelhor, 1979; Gil, 1988; Kearney-Cooke, 1988; McFarland & Baker-Baumann, 1990
- low self-esteem; sense of ineffectiveness	Bruch, 1978; Garner & Olmsted, 1983; Gil, 1983, 1988; Kearney-Cooke, 1988; Meiselman, 1984
- overcompliance	Bruch, 1973, 1978; Kearney-Cooke, 1988; Meiselman, 1984
- perfectionism, either in values or behaviors	Garner & Garfinkel, 1982; Garner & Olmsted, 1983; Meiselman, 1984
- involves body image and sexuality; and body dissaatisfaction	Bruch, 1978; Finkelhor, 1979; Garner & Olmsted, 1983; Kearney-Cooke, 1988; McFarland & Baker-Baumann, 1990
- dissociation and a mind-body split; lack of interoceptive awareness	DSM-III-R, 1987; Garner & Olmsted, 1983; Gil, 1988; Hutchinson, 1985;

Table 7

Some Differing Features of Eating Disorders and Sexual Abuse

Sexual Abuse	Eating Disorders
- a traumatic event(s),	- a coping mechanism
- usually began early in childhood	- often begins in adolescence
- a physical event(s) with a cluster of behavioral & physical outcomes	- a set of self perpetuated behaviors with often severe physical sequelae
- involves another person, the offender,	- often triggered by a perceived traumatic event
- a social tragedy and a personal tragedy, with elements of social stigma	- are often supported by social values, but is a personal and social tragedy in wasted energy, money and preoccupation

Pilot Study: A Professional Survey

In order to confirm what the literature revealed, the writer conducted a preliminary survey of clinicians and researchers perceptions and experiences with eating disorders and sexually abused clients. Ten professionals, clinical practioners and/or researchers who work with eating disorders and sexual abuse were identified by their prominence in the literature or their expertise in therapy. They agreed to volunteer after hearing the scope and nature of the research at which time some were surveyed by telephone (those in other cities) while others were interviewed in person. These practitioners have professional training (ie. MD, Ph.D., or a counsellor with a minimum of Master's degree), and work with or study eating disordered and/or sexually abused clients.

The results of the professional survey were arrived at by content analysis, where each of the interviewees statements for questions 2-4 were written on a 3x5 card and analysed for themes across each question. Those themes are presented here.

The first question presents the categorical and numerical responses and the last question reports in total the responses by all the interviewees.

The ten interviewees fell into two groups: researchers(4) and practitioners or therapists (6).

1. In your practice and/or area of research, do you see a connection between

eating disorders and sexual abuse?

Yes=5 Sometimes=4 No=1

(The therapists were responded with Yes=4, Sometimes=2, No=0 while the researchers were more cautious at Yes=1 Sometimes=2 No=1)

If Yes or sometimes how often would you say these problems occur together out of 10 cases? The average response was 5.4, with a range of 3.0 - 7.5.

The researchers were more cautious in there estimates, while the therapists gave the higher responses.

2. How do you account for the connection?

Most therpists agreed that a badly damaged self esteem and body image can arise from a dysfunctional upbringing where there is a history of sexual abuse and that these are symptoms of a deep and intense pain. Eating disorders were felt to be the acting out of a self-abusive pattern set-up early on in childhood trauma. One practitioner stated that in 100% of his eating disordered clients that there was a critical incidence of a remark made which was received at a vulnerable time and made a deep and profound impact. Another interesting note came from an interviewee who felt that the sense of shame or dirtiness with sexual abuse was related to a purification ritual of starving or purging.

The researchers tended to be cautious about the connection, unsure that this was not simply a reflection of high base-rates of both in the population. Several stated that the variables may constellate in dysfunctional families. Echoing Werner's (1989) hypothesis, it was mentioned that perhaps a general vulnerability exits in families where there is chaos and instability.

3. How did you discover these two problems together?

The researchers discovered it in the literature, or in one to one interviews.

The therapists said that in both individual and group settings this information emerged. For some clients they needed the privacy and trust in a one to one, whereas others benefitted from group support and disclosure.

4. In general terms, how did you deal with these clients?

All therapists recommended a combination of both individual and group work in reaching these clients. One therapist said the information regarding sexual abuse never came in an initial interview. this question was not geared for researchers, outside of the act of referring.

The responses to the final question are reported here in totality for the benefit of practitioners looking for validation or the wisdom from someone else's experience.

5. Recommendations for practitioners for working with clients with eating

disorders and/or a history of childhood sexual abuse or traumatic sexual experience.

In general practice:

-with serious and active eating disorders, have medical support and ideally group support as well

-what's most important is the trust and bonding between therapist and client

-read the literature, and educate yourself about the indicators of both eating disorders, sexual abuse and traumatic sexual events

-do a thorough assessment, physical and emotional

-ask relevant questions in a sensitive way

-recognize that in some cases approaches may work differently for male versus female therapists when dealing with sexual abuse

-recognize your limitations

-particularly in private practice: consult

-you need to refer if your own process is somehow getting in the way of you totally being there for them

-be emotionally available

In interaction with the client:

-one must first stabilize compulsive or addictive behaviors before

dealing with the sexual abuse; this is done by creating safety within the therapist /client relationship, then deal with the abuse history

-watch for the connection regarding how a woman feels about her body, this is a core issue; pay very close attention and focus on it in an on-going basis; use this as an opportunity to talk about abuses suffered

-be aware of denial as a major problem in dysfunctional families and those individuals with addictive problems

-use experiential techniques where re-enactment occurs with newly empowered skills to fight back, and to express the rage

-identify shame as a critical factor in healing body image disturbances and use education and experiential techniques

-let them act their stuff out with you

-focus on healing the child within, with an emphsis on self-responsibility not will-power (autonomy versus control)

-recognize dysfunctional family variables and allow them to grieve

-allow time to develop an awareness of and the attitudes of assertion

-developing assertive skills is of primary importance

-awareness of managing stress and developing positive coping strategies around food that are self-enhancing

-set realistic goals and learn to give up perfectionist and compulsive

-emphasize that it was not their fault (ie.CSA) and to validate them every step of the way for the courage it takes, the power it (healing) will bring

The professional survey underscores the need for accurate information, education and skill building for practitioners in the areas of body image and sexuality, regarding eating disorders and sexual abuse. There is a consensus here that the overlap between eating disorders and sexual abuse is significant and worthy of more attention by researchers and therapists.

The review of the literature reveals striking parallels and dynamics between eating disorders and sexual abuse. The results of the preliminary survey of professionals provided further impetus for the study in order to clarify whether or not a history of sexual abuse and /or a traumatic sexual event occurs in significant numbers in a sample of women with eating disorders.

The Research Questions

This study asks the following research questions:

1. What proportion of women in the eating disorder (ED) support group experienced **no history** of childhood sexual abuse (CSA) or a traumatic

sexual event (TSE) as compared to the low scoring reference group?

2. What proportion of women in the ED support group reported having experienced **a history of CSA &/or TSE** as compared to the proportion found in the low scoring reference group?

3. Which EDI subscales characterize the SHQ NO category and the SHQ YES categories across the entire data set (n=72)?

4. Which EDI subscales characterize the SHQ NO and YES categories withn the ED Support Group, Low Scoring Reference Group and the High Scoring Reference Group?

Chapter 3

Method

Design

This study examined the sexual experience histories of persons in an eating disorder support group. A reference group of female graduate students and undergraduate students were also used to compare the occurence of both of these problems in a normal population not in treatment.

Procedure

The support groups that participated were identified in the community and contacted by telephone, following which interviews were held with the group facilitators to describe the intended research. After their approval was given, the group memberships were addressed during their prospective meeting times. Data were gathered after the nature and purpose of the study was described, as well as the issues of voluntary participation and informed consent. Those wishing to participate were asked to sign a consent form, that was entirely separate from the questionnaires, which was not signed or identified . The questionnaires (both the EDI and SHQ) were stapled together so that the data on both instruments could be matched, without having any identifying information written on the actual form, thus ensuring anonymity. Groups that participated were the University of Victoria Eating Disorder Support Group, Gorge Rd. Hospital Bulimia Support Group and the Bulimia Support Group affiliated with a local practitioner.

For the reference groups, instructors at the University of Victoria were

contacted in order to ask approval. Once this was gained, the researcher attended the beginning of each class to describe the study, issues of voluntary participation and informed consent. The instruments and consent forms were handed out and returned to two separate envelopes, which were then returned to the researcher.

Subjects

Eating Disorder Support Group:

A total of 23 women participated, who were largely self referred and their appropriateness was validated by their EDI scores, a screening tool for eating disorders. The women ranged in age from 18 to 48 years.

Low Scoring Reference Group:

This group of 25 women, ranging in age from 18 to 53 years, came from senior undergraduate and graduate female students, that attended classes at the University of Victoria, and were in the Faculty of Education or School of Nursing. This sample was identified by their similarity in age range to the support group.

In order to assess the occurrence of sexual abuse history in a group with low levels of eating disorders, a low scoring reference group was determined by taking only those participants who have low scores on the EDI. In other words, of the 49 women in the reference category who completed the instruments, only those (n=25) scoring below the group median were used in for statistical comparison. Therefore, according to current literature there should be significantly fewer cases of sexual abuse, incest and a traumatic incident in the low scoring reference group than in the eating disorder support group.

High Scoring Reference Group Participants

Scores of participants in the upper range of EDI scores (n=24) were analyzed in the same fashion as the support group participants. Their results are considered separately, under "High Scoring Reference Group ". The age range of this group was equivocal to the low scoring reference group.

Instruments

The following instruments gathered data for this study:

Eating Disorder Inventory (EDI)

The EDI is a sixty four item, self-report measure that was constructed to assess a number of psychological and behavioral traits common in anorexia nervosa and bulimia. Eight subscales measure (see Appendix A):

1. drive for thinness
2. bulimia
3. body dissatisfaction
4. ineffectiveness
5. perfectionism
6. interpersonal distrust
7. interoceptive awareness
8. maturity fears

The EDI has been used as a screening tool, an outcome measure, an aid in typological research, and an adjunct to clinical judgments with eating disorder patients (Garner & Olmsted, 1984). The original pool of 146 items was generated by clinicians familiar with eating disorder research and who had experience treating patients with the disorder. Each subscale was required to have a coefficient of internal consistency (Cronbach's alpha) above .80 for the AN

samples. Test-retest reliability for the EDI was studied by Wear & Pratz (1987). They reported Pearson product-moment correlations ranging from r=.97 to r= .81 for test-retest reliability of seven of the eight subscales. From a restricted subset of 19 subjects who were considered to be at risk on the basis of their scores, the range was r=.96 to r=.77. Only one subscale, maturity fears, produced a reliability of questionable value (r=.65) in the larger group. Test-retest reliability on the total score for both groups was the same at r=.96.

Sexual History Questionnaire (SHQ)

The SHQ is a condensed and abridged version of Finkelhor's 113 item questionnaire (Finkelhor, 1979), which sought to objectively describe the main features of the experience of sexual victimization as recalled by adult survivors of childhood sexual abuse. The main purpose of the six item item version is simply to determine whether or not there is a history of childhood sexual abuse. Questions one to four request information about the indicators of sexual abuse and these items are taken directly from the Finkelhor questionnaire, with one or two minor changes in format.

Questions five and six ask about the individuals perception of having been victimized or exploited and the possibility of other traumatic sexual experiences that may have occurred, other than incest or sexual abuse.

Many surveys of this kind have been documented (Gagnon, 1965; Landis, 1956; Sgroi, 1982). Validity for responses and reliability is a perennial question in sex research. Some researchers say that validity declines with the threatening

nature of the subject matter. However, it has been found that in most studies involving sexality that there is a fair amount of underreporting (Bradburn et al., 1978; Finkelhor, 1979). Since there is no direct means of checking validity for these responses, results of surveys and questionnaires are checked with other studies done previously. While underreporting is often suspected, it could be that with increased social awareness that a certain hypersensitivity to these issues is occurring. It is the author's assumption that this is not yet the case. Although questionnaires are more limited than interviews, they provide anonymity to the individual and spare the researcher the responsibility of likely having to report where children are still at risk. The data to be gathered from the support groups is assumed to be the subjective experience of each participant and is the current perception of their experience.

Along with their EDI scores, each individual was categorized into one of two groups:

NO: - no history of childhood sexual abuse (CSA)

YES: - a history of both childhood sexual abuse and a traumatic sexual event (TSE)

- childhood sexual abuse only

- a history of a traumatic sexual event only

This classification system was repeated with a counsellor, trained in sexual abuse counselling and who was given the criterion for classification. Out of 72 cases, we differed on only one in the control group.

Chapter 4

Results

These results are given according to the research questions.

1. What proportion of women in the eating disorder (ED) support group experienced **no history** of childhood sexual abuse (CSA) or a traumatic sexual event (TSE) as compared to the reference group?

Twenty six percent or 6 cases of the 23 ED support group participants reported having no history of CSA or TSE . The low scoring reference group reported 14 cases or 56% as having no history of CSA or TSE . These results are illustrated in Table 8.

2. What proportion of women in the ED support group reported having experienced **a history of CSA &/or TSE** as compared to the proportion found in the low scoring reference group?

Seventy four percent or 17 of the 23 participants reported having experienced a history of CSE &/or TSE. The low scoring reference group reported 44% of the participants as having experienced a history of CSA &/or TSE . These results are illustrated in Table 8 (see Appendices F, G, & H for the SHQ Yes category breakdown).

The high scoring reference group (who scored in the upper 50% on the EDI) showed that slightly more than half of this group had experienced a history

of CSA &/or TSE, Although the numbers are not significantly different from the reference group,perhaps this finding shows a trend.

Table 8

Frequency According to SHQ Categories in the ED Support Group, the Low Scoring Reference Group and the High Scoring Reference Group

SHQ Category	ED Support Group (n=23) (no.)	%	Low Scoring Reference Group (n=25) (no.)	%	High Scoring Reference Group (n=24) (no.)	%
NO history (hx) of CSA or TSE	(6)	26.08	(14)	56.0	(11)	45.8
YES a history of CSA &/or TSE	(17)	73.9	(11)	44.0	(13)	54.2

A chi-square analysis of group membership (ED support group and the low scoring reference group) and history of sexual abuse or trauma revealed a statistically significant association exists between eating disorders and history of sexual abuse ($X^2 = 4.41$, df=1, $p = .036$).

3. Which EDI subscales characterize the SHQ NO category and the SHQ YES categories across the entire data set (n=72)?

Findings from an analysis of variance indicated the significant subcales were Drive for Thinness, Ineffectiveness and Interoceptive Awareness (see Table 9). The total EDI score also showed significance a $p<.05$. It appears that people who have history of CSA &/or TSE score significantly higher on the EDI and that the subscales of DT, I, and IA are particularly sensitive. Given the conceptual overlap cited in the review of the literature, where dissociation and the mind-body split are often features of both eating disordered individuals as well as those who have a history of CSA %/or TSE, this is not surprising. However, these results were not found in ANOVA'S on between group comparisons, where no significant variance was noted. This may be due to the smaller group/cell sizes when comparing at this level and due also to the large variations within the subscale scores.

Table 9

Analysis of Variance on **Entire Sample** of the EDI Subscales

Between No and Yes SHQ Categories

(n=72)

EDI subscales	DF	F	Significance (p< .05)
Drive for Thinness	1	4.950	.029
Bulimia	1	3.522	.065
Body Dissatisfaction	1	1.713	.195
Ineffectiveness	1	4.950	.029
Perfectionism	1	1.022	.316
Interpersonal Distrust	1	1.712	.195
Interoceptive Awareness	1	6.079	.016
Maturity Fears`1	1	3.486	.066
Total EDI	1	5.365	.023

4. Which EDI subscales characterize the SHQ NO and YES categories withn the ED Support Group, Low Scoring Reference Group and the High Scoring Reference Group?

The plotting of all the group means (ED Support Group, Low Scoring Reference Group, High Scoring Reference Group) on the EDI Profile Chart (see Illustration 1 , based on statitistics in Appendices J, K & L) validates the groups as representative of their respective populations.

Generally, the mean scores for the ED support group were characteristic of other clinical samples (Garner & Olmsted, 1984), however the Yes category did have higher means across all subscales except DT, which had only a slight difference between means and a high variation (see Appendix J). A within group ANOVA did not produce any signficant results, as there was considerable variation, as evidenced in the sd's, and sample sizes were small in the categories within the groups (see Appendices M, N & O).

Significant differences for the low scoring reference group did not surface on any of the EDI subscales, except that Drive for thinness, Body Dissatisfaction and Interoceptive Awareness showed more variation in the Yes category than in the No category (see Appendix K). Although this is perhaps a statistically weak statement, clinically it may have some significance since it was DT , I and IA which were elevated in the Yes category across the entire data set.

In the ED support group the women who reported a TSE only, generally scored higher across all the EDI subcales and with more variation, except in the Perfectionism scale where they had a lower mean and sd (see Appendix J).

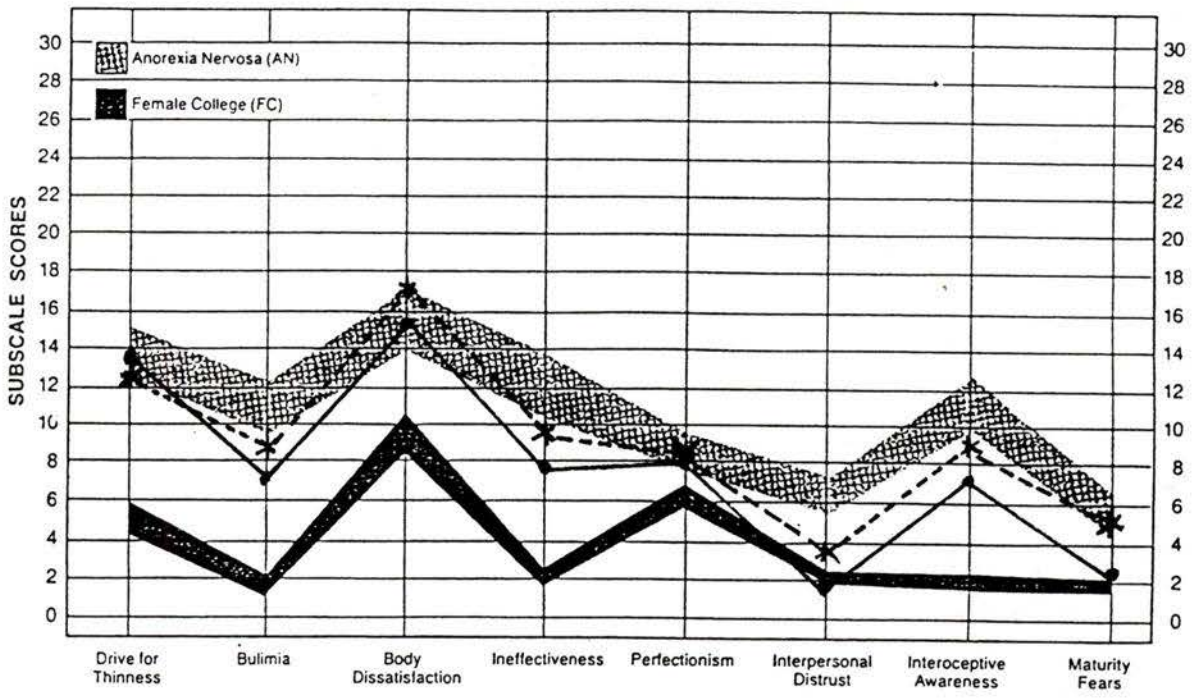
There was a four point spread in mean scores on the Bulimia and Interoceptive Awareness subscales, a three point spread on the Body Dissatisfaction and Ineffectiveness. Due to the limited sample sizes these scores may not be generalizable at this time, but this aspect of this study could generate more attention and research into the impact of TSE's, as different from CSA experiences. It was noted that the two, CSA and TSE occur together often in the ED support group. It is the writer's opinion that , due to the characteristics of PTSD and recall, that some of the TSE clients have a history of CSA as yet unremembered.

The high scoring reference group, scoring in the top 50% on the EDI, had a frequency 46% reporting no history of CSA &/or TSE. Fifty four percent reported a history of CSA &/or TSE (see Appendix H). Their mean scores on the EDI for the No and Yes categories were 38.27 and 48.85 versus the higher mean scores in the ED support group of 64.50 and 73.24, for the No and Yes categories respectively (see Appendices J & L). The high scoring reference group's subscale scores fell within the normal female college data as defined by Garner & Olmsted (1984), except on the Body Dissatisfaction, Ineffectiveness and Interoceptive Awareness subscales. Their Body Dissatisfaction mean put them in the clinical data as defined by Garner & Olmsted (1984). Ineffectiveness and Interoceptive Awareness means were above normal but below the clinical data.

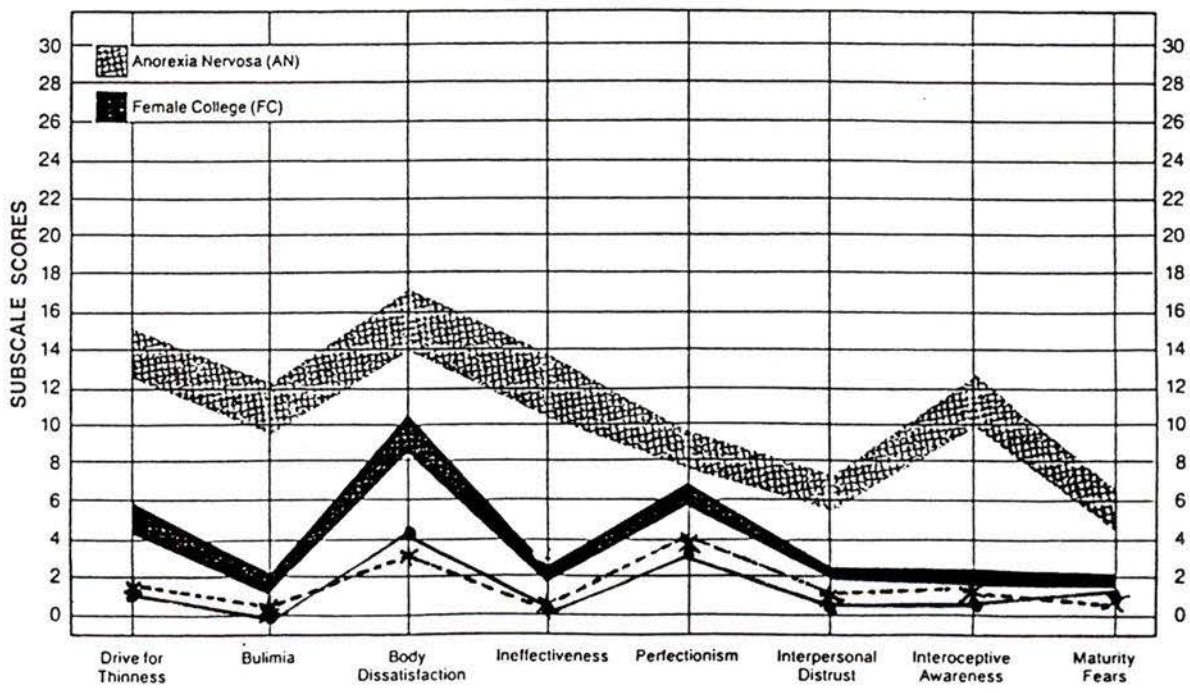
Illustration 1

Eating Disorder Inventory Profile of Mean Scores for the Eating Disorder Support Group, the Low Scoring Reference Group and the High Scoring Reference Group

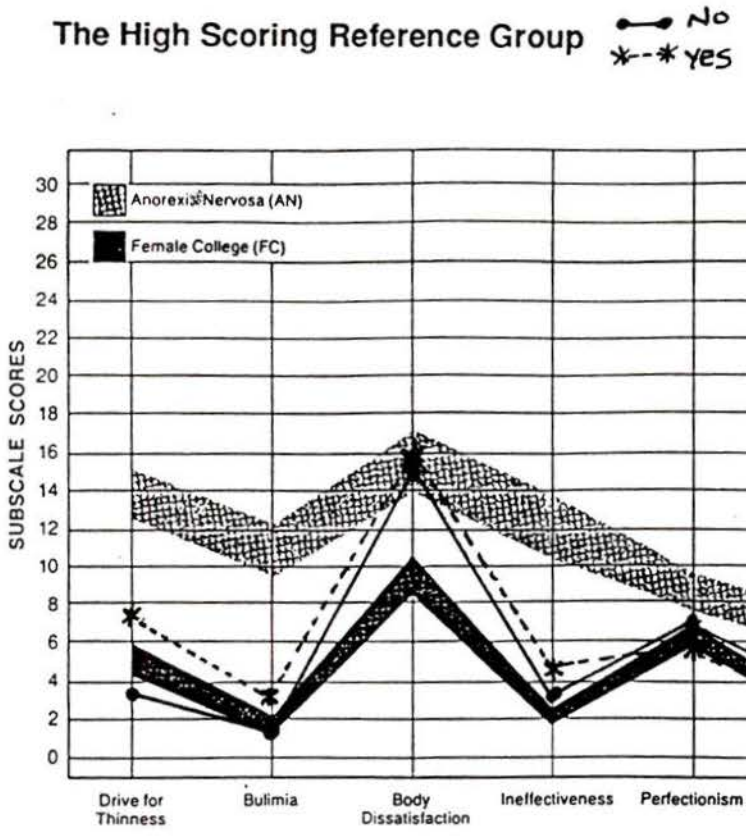
The Eating Disorder Support Group — No / Yes



The Low Scoring Reference Group — No / Yes



The High Scoring Reference Group



From the Group data comparing a clinical sample of women in an Eating Disorder Support Group with a Low Scoring Reference Group, and aHigh Scoring Reference Group across the two measures, the Eating Disorder Inventory and the Sexual History Questionnaire , several themes occurred. Most importantly there is a statistically significant association, as evidenced by the occurrence of a history of childhood sexual abuse and/or traumatic sexual experiences in 74% of the clients in the eating disorder support group and in the chi-square analysis between the eating disorder support group and the low scoring reference group. Other inferences are statistically weak, but may have clinical significance. With high levels of body dissatisfaction rampant in our culture, it behooves both practitioner and researcher to look at this problem with more than a casual acceptance of such attitudes and behaviour as "normal". The role of body image and sexuality, as they are played out in addictive behaviors and in a lack of interoceptive awareness or dissociation in eating disorders and sexual abuse, are important areas for awareness, skill development and personal growth for those people working with individuals and families.

This study validates the findings of other studies that have reported high incidences of these problems occuring together (Kearney-Cooke, 1986; Oppenheimer, 1985; Smolak et al., 1990). Further research may choose to explore in more detail the pathway between eating disorders and sexual abuse and why they so often occur together.

Discussion

This study helps to validate that there is a significant relationship between eating disorders and traumatic sexual experiences such as incest or rape. The salient variables that define this interaction have not yet been established. However, the EDI and SHQ may provide direction in exploring other factors, for example the subscale of Interoceptive Awareness may be valuable to further research in probing the similarities and differences between eating disorders and sexual abuse.

Like eating disorder research and the DSM-III-R problems of definition, sexual abuse researchers have identified problems of definition as well (Finkelhor, 1979; Sgroi, 1982; Wyatt & Peters, 1986). Researchers must clearly establish what they mean by a sexual history or what they consider eating disordered behaviour. According to Meiselman (1984), a sexual abuse experience can be viewed as traumatic life event which can stress the individual's coping mechanisms to the limit with a multitude of side effects and symptomology. The impact of a history of child sexual abuse on adult sexuality is well documented (Fromuth,1986; Geiser, 1979; Gelinas, 1983; Gil, 1988; Maltz, 1987). Any review of the literature on eating disorders and sexual abuse should include studies from both fields. When Coovert et al. (1989) examined the "psychosexual aspects" of anorexia nervosa and bulimia in the literature, their definition of what was considered psychosexual was not clear and their conclusions regarding the presence of sexual abuse from the studies reviewed were based only on eating disorder literature.

Shisslak and Crago (1987) defined the most salient risk factors in developing eating disorders as being sex, age, social class, personality structure, family dynamics, constitutional predisposition, sociocultural pressures and excessive dieting. In the research on sexual abuse, there is evidence to suggest that it is not the experience alone, but a constellation of factors that might include characteristics of dysfunctional families (Bradshaw, 1988) , the meaning attributed to the experience (Brooks, 1987; Silver, Boone & Stones, 1983), support systems (Werner, 1989) and learned methods of coping with stress. More research is required to validate this evidence.

The most obvious connection between eating disorders and sexual abuse seems to be that the individuals act out their pain or their self abusive pattern in their body image and sexuality which are core issues of identity. And where their are dissociative features within the individuals clinical picture, special attention is required by practtioners in order to heal the split.

In order for practitioners to understand the addictive aspects of eating disorders and other behavioural manifestations of addiction more research is needed. Exploring the development of addictions in various populations would be useful as well as investigating the notion of multigenerational transmission of behaviour . Our penal system is heavily populated with males and females from dysfunctional familiy systems, who were under the influence of drugs or alcohol at the time of their offences. The British Columbia Medical Association reported that approximately two thirds of

sexual abuse of children occurs in homes where there is problem drinking and that alcohol plays a similar role in other forms of physical abuse of children (Report on the Task Force on Alcohol and Drug Abuse in the Workplace, 1987). The social costs of these problems are staggering.

The most outstanding characteristic of dysfunctional families can be noted as denial or minimization of the problems at hand. The statistics of this study are grim testimony to the common occurence of sexual abuse and trauma. Our current sociocultural and political attitudes seem to be moving away from denial and toward breaking the silence. In order to create the kind of social change that reflects in healthy and creative individuals, more empirical and phenomenological research needs to be collected and communicated beyond academia. For example, the iatrogenicity of dieting is well known in the field of obesity research. The prevalence of sexual abuse is gaining more empirical validation and the widespread occurence of eating disorders and body dissatisfaction alone are well documented. Generation of this kind of data is useful to researchers but ultimately needs to be translated into application at the individual and social levels.

The complex constellation of variables involved in connecting eating disorders and sexual abuse is well suited to an integration of phenomenological study and quantitative approaches. In a perusal of the literature it appears that there is an either/or approach in design. Family therapy has recognized the value of paradox in conceptualizing families and individuals, where an individual is recognized as unique yet also a hologram

of the family system. Physics allows for the concepts of coherency and focussed energy in lasers and the notion of randomness and chaos. With probability and its basis on samples and populations of people added to the richness of phenomenology which honors the meaning of experience in its own context, the full picture of a problem can be looked at from more than one dimension.

Summary

The descriptive and comparative data in this sudy validates a clinically significant occurence of a history of childhood sexual abuse and/or traumatic sexual events in women who are experiencing eating disorders.

Current attention on the concept of "dysfunctional families" may lead to new areas of research where the higher incidence of physical , emotional, and sexual abuse may be assessed and how this impacts on a child's development of self-esteem. In a society that promotes ideal images of slenderness as a means to self-esteem, it is not surprising that eating disorders may occur more often in people with low self-esteem, including survivors of childhood sexual abuse or traumatic sexual events.

Although many complex sociocultural variables are involved, it is a

grim statistic that even "normal" samples have a high incidence (44%) of childhood sexual abuse and/or traumatic sexual events. It is significant that in 74% of the women in this study's clinical sample have experienced some form of childhood sexual abuse and/or traumatic sexual events.

References

Achimovich, L. (1985). Suicidal scripting in the families of anorectics. Transactional Analysis Journal, 15(1), 21-29.

Andersen, A. E. (1983). Anorexia nervosa and bulimia: a spectrum of eating disorders. Journal of Adolescent Health Care, 4(1), 15-21.

Andersen, A. E. (1986). Sexuality and fertility: women with anorexia nervosa and bulimia. Medical Aspects of Human Sexuality, 20, 138-143.

Armstrong, M. (1987). Women's experience of leaving an abusive partner. Master's thesis, University of Victoria, Victoria, B. C.

Bagley, C., & McDonald, M. (1984). Adult mental health sequels of child sexual abuse and neglect in maternally separated children. Canadian Journal of Community Mental Health, 3(1), 15-26.

Barris, R. (1986). Occupational dysfunction and eating disorders: theory and approach to treatment. Occupational Therapy in Mental Health, 6(1), 27-45.

Basseches, H., & Karp, S. (1984). Field dependence in young anorectic and obese women. Psychotherapy and Psychsomatics, 41(1), 33-37.

Birmingham, C. L. (1983). Obesity: an overview. The British Columbia Medical Journal, 25(7), 346-7.

Bradburn, N., et al (1978). Question threat and response bias. Public Opinion Quarterly. January.

Bradley, P.J. (1985). Conditions recalled to have been associated with weight gain in adulthood. Appetite, 6, 235-241.

Bradshaw, J. (1988). Bradshaw on: the family. Deerfield Beach, Fla.: Healthfield Communications, Inc.

Bradshaw, J. (1988). Healing the shame that binds you. Deerfield Beach, Florida: Health Communications Inc.

Branden, N. (1969). The psychology of self-esteem. Los Angeles: Nash Publishing.

Branden, N. (1971). The disowned self. Toronto: Bantam Books.

Brooks, M. (1987). The search for meaning in adult female survivors of childhood sexual abuse. Doctoral dissertation, Universtiy of Victoria, Victoria, B. C.

Brown, C., & Forgay, D. (1987). An uncertain well-being: weight control and self control. Healthsharing, winter.

Brown, L. (1985). Women, weight and power: feminist theoretical and therapeutic issues. Women and Therapy. 4(1), 61-71.

Brown, M. S. (1977). Normal deveolpment of body image. New York: John Wiley & Sons.

Brownell, K. D., & Foreyt, J. P. (1986). Handbook of eating disorders: physiology, psychology, and treatment of obesity, anorexia, and bulimia. New York: Basic Books Inc.

Bruch, H. (1973). Eating disorders: obesity, anorexia & the person within. New York: Basic Books.

Bruch, H. (1978). The golden cage. Cambridge: Harvard University Press.

Cappon, D. (1973). Eating , loving and dying: a psychology of appetites. Toronto: University of Toronto Press.

Carney, B. (1986). A preventive curriculum for anorexia nervosa and bulimia. University of Windsor, Windsor, Ontario: Bulimia Anorexia Nervosa Association.

Channon, S., & DeSilva, W. P. (1985). Psychological correlates of weight gain in patients with anorexia nervosa. Journal of Psychiatric Research, 19(2), 267- 271.

Chelton, G. L. (1987). Addiction, affects and selfobject theory. Psychotherapy, 24(1), 40-46.

Chernin, K. (191). The Obsession: reflections on the tyranny of slenderness. New York: Harper Colophon Books.

Ciliska, D. (1986). The effects of an intervention program on the self esteem of obese women. Unpublished doctoral dissertation, Universtiy of Toronto.

Clark, J., & Tifft, L., (1966). Interview validation of self-reported deviant behaviour. American Sociological Review, 31, 516-523.

Cleveland, D. (1986). Incest: the story of three women. Toronto: Lexington Books.

Cole, C. L. (1985). A group design for adult female survivors of incest. Women and Therapy, 4(3), 71-82.

Cook, D. (1987). Self-identified addictions and emotional disturbances in a sample of college students. Psychology of Addictive Behaviors, 1(1), 55-61.

Coons, P. M. (1986). Child abuse and multiple personality disorder: review of the literature and suggestions for treatment. Child Abuse and Neglect, 10, 455-462.

Coovert, D.; Kinder, B., & Thompson, J. (1989). The psychosexual aspects of anoresia nervosa and bulimia nervosa: a review of the literature. Clinical Psychology Review, 9(2), 169-180.

Costa e Silva, J. A. (1985). Ethnopsychomotricite et identite: le role de la place du corps de l'enfant et de la mere (Ethnopsychomotricity and identity: the role of the child's and mother's bodies. Annales Medico Psychologiques, 143(10), 985-990.

Crisp, A. H. (1980). Anorexia nervosa: let me be. London: Academic Press.

Davis, R. (1986). Assessing the eating disorders. The Clinical Psychologist, Spring.

Diagnostic and statistical manual of mental disorders, third edition revised (DSM-III-R). (1987). American Psychiatric Association.

DiClemente, C. C. (1986). Self eficacy and the addictive behaviours. Journal of Social and Clinical Psychology, 4(3), 302-315.

Drewnowski, A., & Yee, D. K. (1986). Does dieting cause binging: a social-psychological model of DSM-III bulimia. School of Public Health, University of Michigan (unpublished manuscript, presented at APA convention, August, 1986).

Dubos, R. (1968). Man, medicine & environment. New York: Praeger.

Eisele, J., Hertsgaard, D., & Light, H.K. (1986). Factors related to eating disorders in young adolescent girls. Adolescence, 21(82), 283-290.

Erickson, M. (1985). The case of Barbie: an Ericksonian approach to the treatment of anorexia nervosa. Transactional Analysis Journal, 15(1), 85-92.

Ferrucci, P. (1982). What we may be: techniques for pschological and spiritual growth through psychosynthesis. Los Angeles: Jeremy P. Tarcher Inc.

Finkelhor, D. (1979). Sexually victimized children. New York: The Free Press.

Finkelhor, D. (1984). Sourcebook of Child Sexual Abuse.

Finn, S. E., Hartman, M., Leon, G., & Lawson, L. (1986). Eating disorders and sexual abuse: lack of a confirmation of a clinical hypothesis. International Journal of Eating Disorders, 5(6), 1051-1060.

Fisher, S. (1986). Development and structure of body image (vols. 1-2). Hillsdale, N. J.: Lawrence Erlbaum Associates, Publishers.

Fisk, S. B. (1985). Inpatient treatment of eating disordered clients. Transactional Analysis Journal. 15(1), 93-97.

Foreyt, J.P. (1987). Issues in the assessment and treatment of obesity. Journal of Consulting and Clinical Psychology, 55(5), 677-684.

Freedman, R. (1986). Beauty bound. Toronto: Lexington Books.

Frohlich, J. (1983). Plasma lipoproteins in obesity. The British Columbia Medical Journal, 25(7), 350-351.

Fromuth, M. E. (1986). The relationship of childhood sexual abuse with later psychological and sexual adjustment in a sample of college women. Child Abuse and Neglect, 10, 5-15.

Gagnon, J. (1965). Female child victims of sex offences. Social Problems, 13, 176-192.

Garner, D. M. (1986). Cognitive-behavioural therapy for eating disorders. The Clinical Psychologist, Spring, 36-39.

Garner, D. M. (1986). Psychotherapy for anorexia nervosa and bulimia nervosa. The Clinical Psychologist, Spring, 32-33.

Garner, D. M., & Garfinkel, P. E. (1982). Anorexia nervosa: A multidimensional perspective. New York: Brunner/Mazel.

Garner, D. M., Olmsted, M. P., Polivy, J., & Garfinkel, P. E. (1984). Comparison between weight preoccupied women and anorexia nervosa. Psychosomatic Medicine, 46(3), 255-266.

Garner, D., & Olmsted, M. (1984). Eating Disorder Inventory Manual. Psychological Assessment Resources, Inc.

Garner, D., Olmsted, P., & Polivy J. (1983). Developmentand validation of a multidimensional eating disorder inventory for anorexia nervosa and bulimia. International Journal of Eating Disorders, 2, 15-34.

Geiser, R. L. (1979). Hidden victims. Boston: Beacon Press.

Gelinas, D. (1983).The persisiting negative effects of incest. Psychiatry, 46, 312-332.

Gil, E. (1983). Outgrowing the pain. New York: Dell Publishing Co., Inc.

Gil, E. (1988). The treatment of adult survivors of childhood abuse. Walnut Creek, California: Launch Press.

Glasser, W. (1976). Positive addiction. New York: Harper & Row Publishers.

Goldfarb, L. (1987). Sexual abuse antecedent to anorexia nervosa,bulimia, and compulsive overeating: three case reports. International Journal of Eating Disorders, 6(5), 675-680.

Goode, E. T. (1985). Medical Aspects of the bulimic syndrome and bulimarexia. Transactional Analysis Journal, 15(1), 4-11.

Griffin, S. (1985). Eating issues and fat issues. Transactional Analysis Journal, 15(1), 30-36.

Hambidge, D. M., (1988). Incest and anorexia nervosa: what is the link? British Journal of Psychiatry, Jan, vol 152, 1445-146.

Harter, S., Alexander, P. C., & Neimeyer, R. A. (1988). Long-term effects of incestuous child abuse in college women: social adjustment, social cognition, and family characteristics. Journal of Consulting and Clinical Psychology, 56(1), 5-8.

Heilbrun, A. B. (1986). Preoccupation with stereotyped sex role differences, ideaal body weight, and stress in college women showing anorexic characteristics. International Journal of Eating Disorders, 5(6), 1035-1049.

Hunter, R. S., Kilstrom, N., & Loda, F. (1985). Sexually abused children: identifying masked presentations in a medical setting. Child Abuse & Neglect, 9, 17-25.

Hutchinson, M. G. (1985). Transforming body image. Freedom, California: The Crossing Press.

Interministry Child Abuse Handbook. (1988). Ministry of Social Services and Housing, Province of B. C. Queen's Printer for British Columbia, Victoria.

Janas, C. (1987). Seeking magical solutions, exploring addictions. Medical Hypnoanalysis Journal, 2(1), 15-28.

Johnson, C., & Love, S. Q. (1985). Bulimia: multivariate predictors of life impairment. Journal of Psychiatric Research, 19(2), 343-347.

Johnson, C., Connors, M. E., & Tobin, D. L. (1987). Symptom management of bulimia. Journal of Consulting and Clinical Psychology, 55(5), 668-676.

Jones, D. P. H. (1986). Individual psychotherapy for the sexually abused child. Child Abuse and Neglect, 10, 377- 385.

Jordan, H. W., Howe, G. L., Gelsomino, J., & Lockert, E. W. (1986). Post-traumatic stress disorder: a psychiatric defense. Journal of the National Medical Association, 78(2), 119-126.

Kagan, D. M., & Squires, R. (1984). Eating disorders among adolescents: patterns and prevalence. Adolescence, 19(73), 15-29.

Kaplan, A. S., & Woodside, D. B. (1987). Biological aspects of anorexia nervosa and bulimia nervosa. Journal of Consulting and Clinical Psychology, 55(5), 645-653.

Katz, J. L. (1985). Some reflections on the nature of the eating disorders: on the need for humility. International Journal of Eating Disorders, 4(4), 617- 626.

Kearney-Cooke, A. (1986). Sexuality, body image and eating disorders. Paper presented at the Fifth National Conference on Eating Disorders of the National Anorexic Aid Society, October, Columbus, Ohio.

Kearney-Cooke, A. (1988). Group treatment of sexual abuse among women with eating disorders. Women and Therapy, 7(1), 5-21.

Kinoy, B. (1985). Self-help groups in the management of anorexia nervosa and bulimia: a theoretical base. Transactional Analysis Journal, 15(1), 73-78.

Kline, D. M. (1985). Achieving weight gain with anorexic and bulimic clients in a group setting. Transactional Analysis Journal, 15(1), 62-68.

Kriss, R. T., & Kraemer, H. C. (1986). Efficacy of group therapy for problems with postmastectomy self perception, body image, and sexuality. The Journal Of Sex Research, 22(4), 438-451.

Kubler-Ross, E. (1975). Death - the final stage of growth. Englewood Cliffs, N. J.: Prentice-Hall Inc.

Lamphear, V. S. (1985). The impact of maltreatment on children's psychosocial adjustment : a review of the research. Chid Abuse and Neglect, 9, 251-263.

Lenon, R. (1985). Anorexia nervosa: medical management. Tranactional Analysis Journal, 15(1), 12-16.

Leon, G. R., Lucas, A. R., Ferdinand, R. F., Mangelsdorf, C., & Colligan, R. C. (1987). Attitudes about sexuality and other psychological characteristics as predictors of follow-up status in anorexia nervosa. International Journal of Eating Disorders, 6(4), 477-484.

Lerner, H. D. (1986). Current developments in the psychoanalytic psychotherapy of anorexia nervosa and bulimia nervosa. The Clinical Psychologist, Spring, 39-43.

Levitt, J. L. (1986). Treating adults with eating disorders by using an inpatient approach. Health and Social Work, 11(2), 133-140.

Levy, G. (1983). Une catastrope: la honte (Shame: a catastrophy). Topique Revue Freudienne, 13(31), 25-50.

Lindberg, F. H., & Distad, L. J. (1985). Post-traumatic stress disorders in women who experienced childhood incest. Child Abuse and Neglect, 9, 329-334.

Lindberg, F. H., & Distad, L. J. (1985). Survival responses to incest: adolescents in crisis. Child Abuse and Neglect, 9, 521-526.

Lionells, M. (1986). A reevaluation of hysterical relatedness. Contemporary Psychoanalysis, 22(4), 570-602.

Lister, M., Rosen, K., & Wright, A. (1985). An anti- diet approach to weight loss in a group setting. Transactional Analysis Journal, 15(1), 69-72.

Maine, M. (1985). Effective treaatment of anorexia nervosa: the recovered patient's view. Transactional Analysis Journal, 15(1), 48-54.

Maltz, W., & Holman, B. (1987). Incest and sexuality. Toronto: Lexington Books.

Mannarino, A. P., & Cohen, J. A. (1986). A clinical- demographic study of sexually abused children. Child Abuse and Neglect, 10, 17-23.

Meiselman, K. C. (1984). Incest: a psychological study of causes and effects with treatment recommendations. San Fransisco: Jossey- Bass.

Milkman, H. B., & Shaffer, H. J. (1985). The addictions. Toronto: Lexington Books.

Minuchin, S. (1974). Families and family therapy. Cambridge, Mass.: Harvard University Press.

Mitchell, J. E., Pyle , R. E., & Hatsukami, D. K. (1986). What are atypical eating disorders? Psychosomatics, 27(1), 21-28.

Mitchell, J.E., & Eckert, E.D. (1987). Scope and significance of eating disorders. Journal of Consulting and Clinical Psychology, 55(5), 628-634.

Muni-Brander, P., & Lachenmeyer, J. R. (1986). Eating disorders in adolescent males. CAHPER Journal (Canadian Association for Health, Physical Education and Recreation), 52(4), 27-29.

Muuss, R. E. (1985). Adolescent eating disorder: anorexia nervosa. Adolescence, 20(79).

Muuss, R. E. (1986). Adolescent eating disorder: bulimia. Adolescence, 21(82), 257-267.

Nelson, J. A. (1986). Incest: self-report findings from a nonclinical sample. The Journal of Sex Research, 22(4), 463-477.

Norwood, R. (1985). Women who love too much. New York: Pocket Books.

O'Connell, W. E. (1987). Natural high psychospirituality: stalking shadows with "childlike foolishness". Individual Psychology, 43(4), 502-509.

O'Hare, J. (1983). The reality of incest. Women and therapy, 2(2/3), 215-229.

Oppenheimer, R., Howells, K. Palmer, R and Chaloner, D. (1985). Adverse sexual experience in childhood and clinical eatin disorders: a preliminary description. Journal of Psychiatric Research, 119(2/3), 357-361.

Orbach, S. (1978). Fat is a feminist issue. New York: Berkley Books.

Orlick, T. (1986). Psyching for sport: mental training for athletes. Champaign, Illnois: Leisure Press.

Ornstein, R., & Sobel, D. (1987). The healing brain. New York: Simon & Schuster Inc.

Palmer, C. T. (1988). Twelve reasons why rape is not sexually motivated: a skeptical examination. The Journal of Sex Research, 25(4), 531-536.

Parr, J.P. (1988). Emotional sequelae of abortion. Psychology of Women Quarterly, 12, 461-472.

Patzer, G. L. (1985). The physical attractiveness phenomena. New York: Plenum Press.

Peele, S. (1985). The meaning of addiction. Toronto: Lexington Books.

Polivy, J., & Herman, (1983). Breaking the diet habit. New York: Basic Books.

Polivy, J., & Herman, (1985). Dieting and binging. American Psychologist, 40, 193-210.

Ross, S. (1986). Eating disorders, physical fitness, persons, and physical education. CAHPER (Canadian Association for Health, Physical Education and Recreation), 52(4), 15-20.

Polivy, J., & Herman, C. P. (1987). Diagnosis and treatment of normal eating. Journal of Consulting and Clinical Psychology, 55(5), 635-644.

Rappard, P. (1985). La saintete chimique ou la toxicomanie comme jouissamce non sexuelle (Chemical holiness or drug addiction as non sexual climax). L'information Psychiatrique, 61(3), 369-375.

Report on: Sexual Offences Against Children & Youths, (1984). Committee on Sexual Offences Against Children & Youths. Ottawa, Ont.: Canadian Goveernment Publishing Centre.

Riebel, L. (1985). Eating disorders and personal constructs. Transactional Analysis Journal, 15(1), 42-47.

Romeo, F. F. (1984). Adolescence, sexual conflict and anorexia nervosa. Adolescence, 19(75), 551-555.

Rosellini, G., & Worden, M. (1987). Taming your turbulent past. Pompano Beach, Florida: Health Communications, Inc.

Rossi, E. L. (1986). The psychobiology of mind-body healing. New York: W. W. Norton & Co., Inc.

Roth, D. (1986). Treatment of the hospitalized eating disorder patient. Occupational Therapy in Mental Health, 6(1), 67-87.

Rumney, A. (1983). Dying to please: Anorexia nervosa and its cure. Jefferson, N. C.: Mc Farland & Co.

Rumney, A., & Steckel, T. (1985). Growing up and getting dependency needs met as an adult: reparenting in anorexia nervosa. Transactional Analysis Journal, 151, 55-61.

Ryan, B., & Roughan, P. (1984). Women and weight: a treatment prograamme for both normal and overweight women preoccupied with eating and related issues. Australian Journal of Family Therapy, 5(4), 267-274.

Sallas, A. A. (1985). Treatment of eating disorders: winning the war without having to do battle. Journal of Psychiatric Research, 19(2/3), 445-448.

Sanders, S. (1986). The perceptual alteration scale: a scale measuring dissociation. American Journal of Clinical Hypnosis, 29(2), 95-102.

Sankowsky, M. H. (aka M. Hutchinson) (1981). The effect of a treatment based on the use of guided visio-kinesthetic imagery on the alteration of negative body-cathexis in women. Unpublished doctoral dissertation, Boston University, University Microfilms International.

Sargent, J. (1986). Family therapy for eating disorders. The Clinical Psychologist, Spring, 43-45.

Sauer, R. J. (1982). Family enmeshment. Family Therapy. 9(3), 299-304.

Schaef, A. W. (1986). Codependence misunderstood- mistreated. San Fransisco: Harper & Row.

Schaef, A. W. (1987). When Society Becomes an Addict. San Francisco: Harper & Row.

Schecter, J. O., Schwartz, H. P., & Greenfeld, D. G. (1987). Sexual assault and anorexia nervosa. International Journal of Eating Disorders, 6(2), 313-316.

Schneider, S., Berman, C., & Aronson, D. (1984). Sexuality treaatment issue with a special population of adolescents. Adolescence, 19(73), 201-206.

Schultz, L. G. (1982). Child sexual abuse in historical perspective. Journal of Social Work and Human Sexuality, 1(1/2), 21-35.

Seixas, J. S., & Youcha, G. (1985). Children of alcoholism: a survivors manual. New York: Harper & Row.

Sgroi, S. M. (1982). Family treatment of child sexual abuse. Journal of Social Work and Human Sexuality, 1(1/2), 109-128.

Sgroi, S. M. (1982). Handbook of clinical intervention in child sexual abuse. Toronto: Lexington Books.

Shisslak, C. M., Schnaps, L., & Crago, M. (1986). Interactional group therapy for anorexic and bulimic women. Psychotherapy, 23(4, 598-605.

Shisslak, C. M., Crago, M., Neal, M. E., & Swain, B. (1987). Primary prevention of eating disorders. Journal of Consulting and Clinical Psychology, 55(5),660-667.

Silver, R. L., Boone, C., & Stones, M. H. (1983). Searching for meaning in misfortune: making sense of incest. Journal of Social Issues, 39(2), 81-102.

Sinnett, E. R., Judd, B., & Olson, M. A. (1983). Food, drugs, and alcohol- a common temporal pattern of use. Perceptual and Motor Skills, 57, 375-379.

Slade, P. (1985). A review of body-image studies in anorexia nervosa and bulimia nervosa. Journal of Psychiatric Research, 19(2/3), 255-265.

Slatkoff, S. L. (1985). Body-dissatisfaction in women: theory, group counselling intervention and measurement. Master's thesis, University of Victoria, Victoria, B. C.

Sloan, G., & Leichner, P. (1986). Is there a relationship between sexual abuse or incest and eatin disorders? Canadian Journal of Psychiatry, 31, 656-660.

Small, J. (1982). Transformers: the therapist of the future. Marina del Rey, California: DeVorss & Company.

Smead, V. (1983). Anorexia nervosa, bulimarexia, and bulimia: labeled pathology and the western female. Women & Therapy, 2(1), 19-35.

Smead, V. (1984). Eating behaviours which may lead to perpetuate anorexia nervosa, bulimarexia, and bulimia. Women & Therapy, 3(2), 37-49.

Smead, V. (1985). Labeling eating disorders: weighing the costs and benefits. Transactional Analysis Journal, 15(1), 17-20.

Smith, D. (1981). Unfinished business with informed consent procedures. American Psychologist, 36(1), 22-26.

Smolak, L., Levine, M., & Sullins, E. (1990). Are child sexual experiences related to eating-disordered attitudes and behaviors ina college dample? International Journal of Eating Disorders, 9(2), 167-178.

Sommer, B. (1987). Not another diet book. Toronto: Hunter House Inc.

Spiegel, J., & Machotka, P. (1974). Messages of the body. New York: The Free Press.

Squire, S. (1983). The slender balance. New York: Pinnacle Books.

Stoltz, S. G. (1985). Beware of boundary issues. Transactional Analysis Journal, 15(1), 37-41.

Strober, M., & Bowen, E. (1986). Hospital management of the adolescent with anorexia nervosa. The Clinical Psychologist, Spring, 46-48.

Strober, M., & Humphrey, L. L. (1987). Familial contributions to the etiology and course of anorexia nervosa and bulimia. Journal of Consulting and Clinical Psychology, 55(5), 654-659.

Strober, M., Morrell, W., Burroughs, J., Salkin, B., & Jacobs, C. (1985). A controlled family study of anorexia nervosa. Journal of Psychiatric Research, 19(2/3), 239-246.

Sutton Edmonds, M. (1986). Overcoming eating disorders. Journal of Psychosocial Nursing, 24(8), 19-25.

The Provincial Task Force Eating Disorder Report (Sept, 1989), prepared for the Ministry of Health by the McCreary Centre Society, 3644 Slocan St. Vancouver, B.C., V5M 3E8.

The Task Force Report on Alcohol and Drug Abuse in the Workplace (Sept 1987). Joint sponsorship of the Ministry of Health and Worker's Compensation Board, British Columbia.

The Victoria Women's Sexual Assault Centre Publications Committee (1986). Working with survivors of sexual assault. Victoria: Hillside Printing.

Tze, W. J. (1983). Childhood obesity. The British Columbia Medical Journal, 25(7), 348-350.

Vandereycken, W. (1990). The Addiction Model in Eating Dissorders: some critical remarkds and a selected bibliography. International Journal of Eating Disorders, 9(1), 95-101.

Vognsen, J. (1985). Individual therapy. Transactional Analysis Journal, 15(1), 79-84.

Wardle, J. (1986). Eating style: a validation of the Dutch Eating Behaviour Questionnaire in normal subjects and women with eating disorders. Journal of Psychosomatic Research, 31(2), 161-169.

Wardle, J., & Foley, E. (1989). Body image: stability and sensitivity of body satisfaction and body size estimation. International Journal of Eating Disorders, 8(1), 55-62.

Wear, R., & Pratz, O. (1987). Test-retest reliability of the Eating Disorder Inventory. International Journal of Eating Disorders, 6(6), 767-769.

Weiner, H. (1985). The physiology of eating disorders. International Journal of Eating Disorders, 4(4), 347-388.

Werner, E. (1989). The children of the garden island. Scientific American, 260(4), 96-111.

Wilkie, M. A. (1986). Binge eating in the context of eating disorders: a reference for counsellors. Master's thesis, University of Victoria, Victoria, B. C.

Williamson, D. A., Kelley, M. L., Davis, C.J., Ruggiero, L., & Blouin, D. C. (1985). Psychopathology of eating disorders: a controlled comparison of bulimic, obese and normal subjects. Journal of Consulting and Clinical Psychology, 53(2), 161-166.

Wolman, B. B. (Ed.). (1982). Psychological aspects of obesity. New York: Van Nostrand Reinhold Co.

Woodman, M. (1980). The owl was a baker's daughter. Toronto: Inner City Books.

Woodman, M. (1982). Addiction to perfection. Toronto: Inner City Books.

Woodman, M. (1985). The pregnant virgin. Toronto: Inner City Books.

Wyatt, G. E., & Peters, S. D. (1986). Issues in the definition of child sexual abuse in prevalence research. Child Abuse and Neglect, 10, 231-240.

Appendix A

Definition of Terms

addiction: "An extreme attachment to an experience that is acutely harmful to you but which you feel compelled to repeat again and again because it feels essential to your life and extremely difficult to give up." (Peele, 1985, p.87).

anorexia nervosa: the relentless pursuit of thinness (Bruch, 1973) characterized by an intense fear of fat, a weight loss of 25% of original body weight (DSM-III-R, 1987), maintenance of low weight by continuous voluntary control and restriction of their food intake, and a disturbance of body image.

binge eating: episodes of eating that are uncontrolled and excessive, where large quantities of food are consumed rapidly (Wilkie, 1986) providing a transient sense of relief, followed by distress (ie. shame, guilt, self-loathing).

body dissatisfaction (BD): EDI subscale; reflects the belief that specific parts of the body associated with shape change of increased "fatness" at puberty are too large (e.g., hips, thighs, buttocks). Body dissatisfaction has been found to be related to other body image disturbances which have been considered a basic deficit in anorexia nervosa . Crisp (1977, 1980) has suggested that dieting in anorexia nervosa is a response to dissatisfaction with

pubertal "fatness" and the symbolic meaning that it has for the individual (Garner & Olmsted, 1984).

body image: the conscious or unconscious subjective experience and mental representation of the body, including sensations, visual appraisal, proprioceptive awareness, feelings and attitudes toward the body (Sankowsky, 1981).

bulimia: recurrent episodes of binge eating usually followed by weight control methods such as severely restricted dieting, self-induced vomiting, or use of cathartics or diuretics. According to the EDI subscales, bulimia (B) indicates the tendency toward episodes of uncontrollable overeating (bingeing) and may be followed by the impulse to engage in self-induced vomiting. The presence or absence of bulimia differentiates subtypes of anorexia nervosa (Gaarner & Olmsted, 1984).

CSA: childhood sexual abuse

drive for thinness (DT): is an EDI subscale which indicates excessive concern with dieting, preoccupation with weight, and entrenchment in an extreme pursuit of thinness (Garner & Olmsted, 1984). It is a cardinal feature of anorexia nervosa, which includes an ardent wish to lose weight and a fear of weight gain.

eating disorder: a range of behaviors, physiological and psychological characteristics, from anorexia nervosa, bulimia, recurrent dieting, to compulsive overeating and obesity; where preoccupation with weight and body image are life disturbing issues.

hx: history

ineffectiveness (I): is an EDI subscale which assesses feelings of general inadequacy, insecurity, worthlessness, and the feeling of not being in control of one's life. Both concepts of locus of control and a negative self-evaluation are components of this subscale (Garner & Olmsted, (1984). Ineffectiveness has been described as a fundamental feature of anorexia nervosa (Bruch, 1973; Selvini-Palazzoli, 1978).

interoceptive awareness (IA): is an EDI subscale reflecting one's lack of confidence in recognizing and accurately identifying emotions of visceral sensations of hunger or satiety. Bruch (1962, 1978) and Selvini-Paalzzoli (1978)have described this deficiency in interoceptive labeling as fundamental to anorexia nervosa and there is some empirical support for the existence of deficits in this area (Garfinkel & Garner,1982; Garner & Olmsted, 1984).

interpersonal distrust (ID): in an EDI subscale which reflects a sense of alienation and a general reluctance to form close relationships and has been

identified as important in the development and maintenance of anorexia nervosa. It is to be distinguished from paranoid thinking and relates to an inability to feel comfortable expressing emotions towards others (Garner & Olmsted, 1984).

maturity fears (MF): is an EDI subscale which measures one's wish to retreat to the security of preadolescent years because of the overwhelming demands of adulthood (Garner & Olmsted, 1984).

obesity: for the limits of this study, obesity here refers to the results of compulsive overeating. A generally accepted definition of obesity is when body weight is more than 20% above the upperlimit for height. However, more research is necessary in defining obesity, when it is a problem and when it is not. Plus there is concern that there are iatrogenic factors involved in some cases of obesity, where dieting was prescribed.

perfectionism (P): is an EDI subsclae which indicates excesssive expectation of superior achievement with a sense of overcompliance (Bruch, 1978; Garner & Olmsted, 1984).

sexual abuse:
"...means any sexual exploitation of a child whether consensual or not. It includes touching of a sexual nature and sexual intercourse, and may include any behavior of a sexual nature toward a child. In determining whether behavior is of a sexual nature, one should ask whether a reasonable observer, looking at

the behavior in its context, would conclude that it is. This would exclude normal affectionate behavior towards children and normal health or hygiene care. Sexual activity between children may constitute sexual abuse if the difference in age or power between the children is so significant that the older or more powerful child is clearly taking sexual advantage of the younger or less powerful child. This would exclude consensual, developmentally appropriate sexual activity between children where there is no significant difference in age or power between the children" (Inter-ministry Child Abuse Handbook, Province of B. C., 1988, p.10-11).

This definition of sexual abuse includes incest.

TSE: traumatic sexual event

traumatic sexual event: any sexual event, witnessed or experienced, including rape, sexual assault, abortion, or a traumatic first sexual experience, which the participant percieves as having been a negative experience.

Appendix B

Dear Potential Participant:

As a part of completing my master's degree in Counselling Psychology at the University of Victoria, I am conducting research exploring both sexual abuse and eating disorders.

To participate in this study you will be required to fill out two questionnaires, that may take 30-45 minutes to complete. Some of the questions are very personal and pertain to information you may not have shared with anyone or few people before. Therefore to ensure your complete anonymity and confidentiality , I will ask you to sign a consent form, which will in no way be attached to your questionnaires.

The data I have gathered from the groups participating will be published in my thesis, entirely anonymous.

If completing these questionnaires raises any immediate issues for you, or if you would like information about immediate support services, please call me: **Shannon Lavell, ph. 381-7702,** or contact your group leader.

If you elect to participate, it is important that every question be answered so that your questionnaires can contribute to the study. Understand that your participation is voluntary and that you may withdraw at any time.

Upon completion of the study, I encourage you to contact me if you are interested in the findings.

Thank you for your attention.

Sincerely,

Shannon Lavell, RN, BSN, MA(cand.)

Appendix C

CONSENT FORM

I, _____ consent to being a participant in the a descriptive study on Eating Disorders and Sexual Abuse.

I understand that full anonymity is assured me, in that my name will not be on my questionnaires and that this consent form will be separate from the questionnaires, ensuring that one cannot be identified with the other.

Because of the voluntary nature of the participation, I understand that I may withdraw at any time before the questionnaires are completed and handed in.

_____

signature

Appendix D

SEXUAL HISTORY QUESTIONNAIRE

Please check or answer the following:

M___ F___

age_____

married____
single____
separated ____
divorced____

no. of children____

It is now generally realised that most people have sexual experiences as children and while they are still growing up. Some of these are with friends and playmates, and some with relatives and family members. Some are very upsetting and painful, and some are not. Some influence people's later lives and sexual experiences, and some are practically forgotten.

'Sexual' may be defined as: touching of a sexual nature, sexual intercourse, or any behaviour perceived as sexual, excluding normal affectionate behaviour, or normal health or hygiene care.

Try to remember the sexual experiences you had while growing up. Remember, the information obtained will be entirely anonymous.

1. Did you have any of the following experiences as a child?
(please circle the letter(s) that indicate your experience)

a. any invitation to do something sexual
b. kissing or hugging in a sexual way
c. another person showing his/her sex organs to you
d. you showing your sex organs to another person
e. another person fondling you in a sexual way
f. you fondling another person in a sexual way
g. another person touching your sex organs
h. you touching another person's sex organs
i. intercourse, but without attempting penetration
j. intercourse
k. other_____

2. How old were you when these experiences first began?

3. Your relationship to the other person in the most significant experience, was:
(please check)

a. stranger___
b. person you knew but not a friend___
c. friend___
d. father___
e. mother___
f. brother___
e. sister ___
g. stepfather___
h. stepmother___
i. aunt___
j. uncle___
k. cousin___

l. friend of your parents___
m. other_____

4. In retrospect, would you say these experiences were: (please check)

a. positive___
b. mostly positive___
c. neutral___
d. mostly negative___
e. negative___

5. Do you perceive yourself as having been sexually abused or exploited as a child? (make an X on the line to indicate your answer)

strongly agree — uncertain — strongly disagree

|_____|_____|_____|_____|

6. Have you had any of the following sexual experiences which were traumatic for you? (please check any of the following)

a. none___
b. rape or sexual assault___
c. unwanted pregnancy___
d. abortion___
e. a traumatic first sexual experience___
f. witnessing a traumatic or violent sexual event

g. other_____

Appendix E

Professional Survey

Dear Sir or Madam:

I am conducting research on eating disorders and sexual abuse. New literature and research is emerging which links the two problems. Naturally, the driving force behind this research is the observations and experiences of front line clinicians and researchers. To illuminate current professional observations and experiences, would you be interested in participating in the 'professional survey ' aspect of my study?

The survey questions are attached for your perusal.

If you are interested in participating you may call me directly or wait for my telephone call within the week of receiving this notice, at which time we may discuss the questions, arrange an interview time, or I will accept your wish not to participate. Upon completion of the study, I will mail you a summary of my findings, if you so desire.

Thank you for your time and attention.

Sincerely,

Shannon Lavell, RN, BSN, MA (cand.)

Survey Questions

1. In your practice and/or area of research, do you see a connection between eating disorders (ie. obesity, weight preoccupation, bulimia and anorexia nervosa) and sexual abuse (ie. history of childhood sexual abuse, incest, or a traumatic sexual event)?

YES____ NO____ SOMETIMES_____

If yes or sometimes, out of ten eating disorder cases, how often whould you say these two problems occur together?

____
10

2. If so, how do you account for the connection?

3. How did you discover these two problems together? Or, how did this information emerge? (ie. in individual counselling, group sessions,, intake interview; what kind of questions/treatment methods elicited this information)

4. In general terms, how did you deal with these clients? (ie. focus of counselling, types of intervention, referral)

5. What recommendations would you make to other practitioners regarding working with these clients?

Appendix F

ED Support Group: Frequency According to SHQ Categories
(n=23)

SHQ Category	Frequency	%	Cum. %
1. no history (hx) of CSA or TSE	6	26.08	100
2. hx of CSA & TSE	9	39.13	73.9
3. hx of CSA only	1	4.34	34.77
4. hx of TSE only	7	30.43	30.43

Appendix G

Low Scoring Reference Group: Frequency According to SHQ Categories (n=25)

SHQ Category	Frequency	%	Cum. %
1. no hx of CSA or TSE	14	56.0	100.0
2. hx of CSA & TSE	3	12.0	44.0
3. hx of CSA only	3	12.0	32.0
4. hx of TSE only	5	20.0	20.0

Appendix H

High Scoring Reference Group: Frequency According to SHQ Categories (n=24)

SHQ Category	Frequency	%	Cum. %
1. no hx of CSA or TSE	11	45.8	100.0
2. hx of CSA & TSE	4	16.7	54.2
3. hx of CSA only	3	12.5	37.5
4. hx of TSE only	6	25.0	25.0

Appendix I

Total Reference Group*: According to SHQ Categories
(n=49)

SHQ Category	Frequency	%	Cum. %
1. no hx CSA or TSE	25	51.02	100.0
2. hx of both CSA & TSE	7	14.28	48.96
3. hx of CSA only	6	12.24	34.68
4. hx of TSE only	11	22.44	22.44

Appendix J

Eating Disorder Inventory Mean Subscale Scores
for the ED Support Group According to SHQ No* and Yes* Categories

(n=23)

EDI Subscales	No (n=6) mean (sd)	Yes (n=17) mean (sd)
DT	13.83 (2.86)	12.94 (5.87)
B	7.33 (5.74)	8.41 (5.78)
BD	15.67 (6.38)	16.82 (6.65)
I	7.83 (5.38)	9.77 (6.62)
p	8.17 (4.75)	8.35 (4.21)
ID	2.00 (1.55)	3.59 (3.16)
IA	7.33 (2.34)	8.88 (5.67)
MF	2.33 (2.34)	4.59 (4.19)
Total EDI	64.50 (20.92)	73.24 (29.19)

* No= SHQ group 1, no hx of CSA or TSE
* Yes= SHQ groups 2, 3, &4, with hx of CSA &/or TSE

Appendix K

Eating Disorder Inventory Mean Subscale Scores
for the Low Scoring Reference Group According to SHQ No and Yes Categories
(n=25)

EDI Subscales	No (n=14) mean (sd)	Yes (n=11) mean (sd)
DT	1.14 (1.61)	1.45 (2.42)
B	.14 (.36)	.00 (.00)
BD	4.29 (3.93)	3.09 (4.18)
I	.14 (.54)	.18 (.60)
P	3.43 (3.06)	3.91 (2.88)
ID	.29 (.61)	.55 (1.21)
IA	.50 (1.16)	1.18 (2.44)
MF	.86 (1.41)	.73 (1.01)
Total EDI	10.79 (5.39)	11.09 (6.69)

Appendix L

Eating Disorder Inventory Mean Subscale Scores for the
High Scoring Reference Group According to SHQ No and Yes Categories

(n=24)

EDI Subscales	No (n=11) mean (sd)	Yes (n=13) mean (sd)
DT	3.73 (3.38)	6.92 (6.82)
B	2.00 (2.60)	3.00 (4.83)
BD	14.72 (6.54)	15.39 (6.21)
I	3.00 (3.03)	4.36 (3.93)
P	6.82 (3.68)	6.46 (4.56)
ID	3.55 (3.50)	3.23 (3.11)
IA	2.73 (1.68)	4.62 (4.94)
MF	1.91 (1.22)	2.00 (1.87)
Total EDI	38.27 (15.04)	45.85 (26.29)

Appendix M

Eating Disorder Inventory Mean Scores for the ED Support Group According to NO and Yes SHQ Categories (2-4)

(n=23)

EDI subscales	No (n=6) mean (sd)	Yes SHQ 2 (n=9) mean (sd)	SHQ 3 (n=1) mean (sd)	SHQ 4 (n=7) mean (sd)
DT	13.83 (2.86)	12.11 (4.89)	6.00 --	15.00 (6.78)
B	7.33 (5.57)	6.22 (4.43)	8.00 --	11.28 (6.78)
BD	15.68 (6.38)	16.11 (5.84)	12.00 --	18.43 (8.04)
I	7.83 (5.38)	8.00 (3.91)	5.00 --	12.71 (8.83)
P	8.17 (4.75)	8.89 (4.51)	12.00 --	7.14 (3.98)
ID	2.00 (1.55)	2.44 (3.05)	4.00 --	5.00 (3.16)
IA	7.33 (5.16)	7.89 (6.05)	3.00 --	11.00 (4.93)
MF	2.33 (2.34)	4.11 (3.33)	0.00 --	5.86 (5.15)
Total EDI	64.50 (20.93)	65.56 (21.50)	50.00 --	86.43 (35.71)

Appendix N

Eating Disorder Inventory Mean Scores for the Low Scoring Reference Group According to No and Yes SHQ Categories (2-4)

(n=25)

EDI subscales	No (n=14) mean (sd)	Yes SHQ 2 (n=3) mean (sd)	SHQ 3 (n=3) mean (sd)	SHQ 4 (n=5) mean (sd)
DT	1.14 (1.61)	.33 (.58)	4.33 (3.22)	.40 (.89)
B	.14 (.36)	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)
BD	4.29 (3.93)	2.68 (4.62)	2.67 (2.52)	3.60 (5.41)
I	.14 (.54)	0.00 (0.00)	0.00 (0.00)	.40 (.89)
P	3.43 (3.06)	3.33 (4.16)	3.33 (2.31)	4.60 (2.88)
ID	.29 (.61)	1.33 (2.31)	.33 (.57)	.20 (.45)
IA	.50 (1.16)	0.00 (0.00)	1.67 (2.89)	1.60 (3.05)
MF	.86 (1.41)	.67 (.58)	1.67 (1.53)	.20 (.45)
Total EDI	10.79 (5.40)	8.33 (6.66)	14.00 (7.21)	11.00 (7.18)

Appendix O

Eating Disorder Inventory Mean Scores for the High Scoring Reference Group According to NO and Yes SHQ Categories (2-4)

(n=24)

EDI subscales	No (n=11) mean (sd)	Yes SHQ 2 (n=4) mean (sd)	SHQ 3 (n=3) mean (sd)	SHQ 4 (n=6) mean (sd)
DT	3.73 (3.38)	6.75 (7.63)	6.67 (8.15)	7.17 (7.08)
B	2.00 (2.61)	3.25 (3.56)	7.00 (8.71)	.83 (1.60)
BD	14.73 (6.54)	17.75 (5.31)	14.33 (8.08)	14.33 (6.56)
I	3.00 (3.03)	4.25 (5.31)	4.67 (5.69)	4.33 (2.66)
P	6.82 (3.68)	6.75 (4.11)	5.00 (7.81)	7.00 (3.69)
ID	3.55 (3.50)	3.75 (4.11)	6.00 (3.00)	1.50 (1.05)
IA	2.73 (1.68)	4.00 (4.08)	9.67 (7.23)	2.50 (2.58)
MF	1.91 (1.22)	1.75 (1.50)	3.67 (2.89)	1.33 (1.21)
Total EDI	38.27 (15.04)	48.25 (19.47)	56.33 (48.27)	39.00 (19.30)

Appendix P

Eating Disorder Inventory Information

The package of copyrighted materials for the Eating Disorder Inventory may be obtained through:

M. D. Angus and Associates Ltd.
2639 Kingsway Avenue
Port Coquitlam, B.C.
V3C 1T5

(604) 464-7919
(604) 464-1466

Publishers of: The Testing Materials Resource Book for Psychologists, Speech Pathologists, Vocational Counsellors and Teachers (1988).

VITA

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Title of Thesis: A HISTORY OF SEXUAL ABUSE IN A SAMPLE OF WOMEN WITH EATING DISORDERS

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26 August 1990
(Date)