Childhood and Adulthood Abuse in Bulimic and Nonbulimic Women: Prevalences and Psychological Correlates

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Abstract: Objective: We evaluated associations between childhood physical and sexual abuse in bulimic women and eating disturbances, psychiatric symptoms, and likelihood of later abuse in adulthood. Method: Fifty-one bulimics and 25 normal eaters participated in this study. Semistructured interviews and self-report measures were used to assess eating symptoms, comorbid psychiatric disturbances, personality pathology, and childhood and adulthood abuse. Results: Compared with the normal eaters, bulimic women reported higher levels of childhood abuse. Although bulimic women showed more psychopathology than nonbulimic women, there was a correspondence between the presence and severity of abuse and the severity of concurrent psychopathologic symptoms. Results linked dissociation and submissiveness to most severe forms of abuse. Abuse in adulthood was almost always preceded by earlier abuse during childhood. Discussion: Our findings suggest an association between certain psychopathologic traits and the likelihood of abuse (especially when occurring both in childhood and adulthood). Observed associations could implicate causal effects of childhood abuse on personality development, influences of personality traits in heightening the risk of abuse, or both. © 2003 by Wiley Periodicals, Inc. Int J Eat Disord 33: 397–405, 2003.

Key words: childhood abuse; adulthood abuse; bulimic women; nonbulimic women; psychological correlates

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INTRODUCTION

Thirty percent to 45% of women with bulimia nervosa (BN) report having experienced childhood sexual abuse (Connors & Morse, 1993; Wonderlich, Brewerton, Jocic, Dansky, & Abbott, 1997) and even more women report that they had been abused physically (Rorty, Yager, & Rossootto, 1994). Two studies reported that bulimic women report a high prevalence of unwanted sexual experiences in adulthood (Dansky, Brewerton, Kilpatrick, & O'Neil, 1997; Wonderlich et al., 2001). One of these studies evaluated the effects of multiple sexual assaults on eating-disordered behavior in a community sample (Wonderlich et al., 2001). These authors found that individuals who experienced both childhood and adult sexual abuse showed marked eating disorder symptomatology and impulsivity compared with individuals who experienced no abuse, with individuals who were only abused sexually in childhood, or with individuals who were only abused sexually in adulthood. These findings suggest that repeated abuse may be associated with more severe eating disorders and generalized symptoms. To our knowledge, no other study has studied implications of repeated abuse in bulimic women.

Studies conducted in the general population have shown that a history of childhood abuse (sexual or physical) is associated with greater risk of being abused later in life (Kessler & Bieschke, 1999; Nishihi, Mechanic, & Resick, 2000). Maladaptive behaviors, diminished self-efficacy, learned messages about self-worth, lack of protective skills, and low self-esteem are some of the mediating variables that could explain these revictimization effects (Messman & Long, 1996).

The current study assessed the proportion of women, in a sample of bulimic and normal-eater women, who had experienced childhood abuse and then later abuse in adulthood. It also explored the possible implications of repeated abuse, across childhood and adulthood, for eating symptoms and associated psychopathologic traits.

METHODS

Participants

Bulimic participants (n = 51) were recruited through outpatient services at a specialized eating disorders program. Eating disorder diagnoses were confirmed using the Eating Disorders Examination (EDE; Fairburn & Cooper, 1993). According to EDE interviews, 39 (76.5%) of the bulimic participants met criteria for BN, purging subtype; 6 (11.8%) for BN, nonpurging subtype; 5 (9.8%) for a subclinical BN purging subtype; and 1 (2%) for a subclinical BN nonpurging subtype. These criteria are outlined in the 4th ed. of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychiatric Association, 1994). Mean ± SD age and body mass index (BMI) in this sample were 24.71 ± 6.52 years and 21.67 ± 2.79 kg/m², respectively. Normal-eater controls (n = 25) were recruited from classes at different Montreal universities and through public advertisements (so as to approximate the distribution of student and nonstudent participants in our bulimic subgroup). They were included in the study if they showed no past or present eating disorders upon EDE interview and no psychiatric history. Mean ± SD age and BMI in this group were 23.18 ± 5.87 years and 21.52 ± 1.79 kg/m², respectively.
Measures

Eating symptomatology was assessed using the EDE, a standardized instrument that indicates the presence and severity of eating disorder symptoms. Reliability exceeds .90 on all but 3 of the 62 EDE items. The EDE also has good internal consistency and discriminant validity.

The Eating Attitudes Test (EAT-26; Garner, Olmsted, Bohr, & Garfinkel, 1982) measured the attitudes and behaviors characteristic of individuals with eating disorders. With an alpha of .85, a cutoff score of 20 differentiates between clinical and nonclinical disturbances.

Experiences of childhood sexual and physical abuse were assessed using the Childhood Trauma Interview (CTI; Fink, Bernstein, Handelsman, Foote, & Lovejoy, 1995). Reported interrater reliabilities for the CTI range from .92 to .99 for severity and frequency scores.

Experiences of sexual and physical abuse in adulthood were assessed using the Trauma Assessment for Adults (TAA; Resnick, 1996). The TAA is a 14-item questionnaire that estimates the presence, type, and severity of traumatic experiences.

Various personality dimensions were assessed using the Dimensional Assessment of Personality Pathology Basic Questionnaire (DAPP-BQ; Livesley, Jackson, & Schroeder, 1992). The DAPP-BQ contains 18 subscales (rejection, compulsivity, callousness, stimulus seeking, intimacy problems, cognitive distortion, anxiousness, affective instability, self-harming behaviors, suspiciousness, insecure attachment, social avoidance, narcissism, identity problems, passive aggressiveness, restricted expression, conduct problems, and submissiveness). Alpha values range from .87 to .94, representing factor-based dimensions obtained in large, independent population samples.

The Centre for Epidemiological Studies Depression Scale (CES-D; Weissman, Sholomskas, Pottenger, Prusoff, & Locke, 1977) is a 20-item self-report symptom scale that measured depressed mood.

The Barrat Impulsivity Scale (BIS; Barrat, 1985) measured impulsivity. The BIS has good internal consistency and reliability.

On the assumption that dissociative symptoms bear a theoretic link to trauma, we used the Dissociative Experiences Scale (DES; Bernstein & Putnam, 1986) to assess dissociation. Split-half reliability on the DES ranges from .71 to .96 and test-retest reliabilities are good.

Given a bilingual population, we used official and validated French translations of the EAT-26, DES, and CES-D. In addition, we developed French translations for other scales using careful forward and back translation techniques.

Procedure

All participants provided written informed consent for research before completing interviews and questionnaires. Compensation for participation ranged from $25.00 to $125.00, depending on the level of participation.

Statistical Analyses

Continuous variables were analyzed using analysis of variance (ANOVA) techniques. Where collineairities existed among measures, we applied multivariate analysis of variance (MANOVA), followed by univariate ANOVAs and planned group comparisons (using Student-Newman-Keuls). For frequency variables, we applied chi-square tests.
RESULTS

Prevalence of Abuse

A severity score of 2 or greater on the CTI for sexual abuse indicated that childhood sexual abuse had occurred at or before the age of 14 years. Minimum threshold criteria for sexual abuse include serious "noncontact" experiences, such as being made to observe an adult masturbate, or lesser "contact" experiences, such as being held in a highly sexualized way. A severity score of 3 or greater on the CTI for physical abuse indicated that childhood physical abuse had occurred at or before the age of 14 years. The threshold for physical maltreatment refers to such experiences as being hit and bruised with an object or being pushed so hard as to be knocked down.

Childhood sexual abuse was reported by 20 (39.2%) of the 51 bulimic women and 8 (32%) of the 25 nonbulimic women. Childhood physical abuse was reported by 31 (60.8%) bulimic women and 8 (32%) of the controls. Chi-square tests revealed significantly higher proportions of bulimic women reporting histories of sexual abuse, $\chi^2(1) = 5.14, p < .05$, and physical abuse, $\chi^2(1) = 13.56, p < .001$, compared with controls. Eleven (21.6%) bulimic women and 3 (12%) controls reported having experienced both sexual and physical abuse in childhood. Sexual abuse in adulthood was reported by 10 (19.6%) bulimic women and 3 (12%) controls and physical abuse in adulthood was reported by 10 (19.6%) bulimic women and none of the controls. Five (9.8%) bulimic women and none of the controls reported having experienced both sexual and physical abuse in adulthood.

Data reflecting the co-occurrence of childhood and adult abuse were evaluated for the combined presence of any form of abuse (physical or sexual), and then for each form alone. Among 15 of the bulimic women who reported some form of abuse in adulthood, all but 1 (93.3%) had experienced at least one form of childhood abuse. Likewise, among 3 control women who reported adult abuse, all (100%) had experienced some form of childhood abuse. These findings indicate a striking interdependence between childhood abuse and the risk of abuse in adulthood.

Data corresponding to individual forms of abuse alone indicate a similar tendency. Of the 15 bulimic women who reported sexual abuse in adulthood, 9 (60%) had been abused sexually in childhood. Of the 15 bulimic women who had been abused physically as adults, 5 (33.3%) had been abused physically in childhood. Similarly, all 3 control women who reported sexual abuse in adulthood had been abused sexually in childhood.

Group Comparisons

We evaluated the psychopathologic correlates of childhood and adulthood abuse through group comparisons. To ensure adequate numbers for statistical analyses, we collapsed physical and sexual abuse into a single abuse category. We note, however, that findings obtained were comparable to those obtained when we evaluated instances of sexual abuse alone.

Subgroups

Our sample supported subdivision of participants into five groups: normal-eater women with no history of abuse (control/no abuse, n = 15), normal-eater women with a history of abuse in childhood only (control/child abuse, n = 10), bulimic women with no history of abuse (BN/no abuse, n = 11), bulimic women with a history of abuse in childhood only (BN/child abuse, n = 25), and bulimic women with a history of abuse in
childhood and adulthood (BN/child and adult abuse, \(n = 15\)). As only 3 normal-eater participants reported a history of abuse both in childhood and adulthood, we excluded these cases from the analysis. Similarly, 1 bulimic participant, the only 1 with a history of abuse in adulthood only, was also excluded. None of the normal-eater participants had experienced abuse in adulthood only.

**Eating Symptoms**

Table 1 shows the means (±SD) on measures of eating symptoms (binge frequency, vomit frequency, and EAT-26 scores) for the bulimic and control groups. Given zero binge and vomit frequencies for the control group, we did not apply statistical tests for bulimic/nonbulimic differences on these variables. Results of one-way ANOVAs indicate no significant group effects (across bulimic groups) on binge and vomit (calculated among vomiters only) frequencies. The means for vomit frequency reflect an elevated score for the BN/child and adult abuse group. However, no significant difference was detected. This elevation is attributable to extreme scores in four cases (which represent a third of that subgroup). As for EAT-26 scores, a significant group effect was found, \(F(4,71) = 75.73, p < .001\). Bulimics demonstrated more pathologic eating attitudes than normal-eaters.

**Psychiatric Symptoms**

Table 2 shows the mean (±SD) scores for the five groups on impulsivity (BIS total score), dissociation (DES total score), depression (CES-D total score), and personality dimensions (DAPP subscales). Given statistical redundancies among measures of comorbid symptoms, one-way MANOVA was used to test the overall group effects across all measures. The MANOVA yielded a reliable omnibus effect: Wilks’s lambda \((84,184) = 1.48, p < .05\). Therefore, we proceeded to univariate ANOVAs. The impulsivity, \(F(4,71) = 4.65, p < .01\), dissociation, \(F(4,71) = 2.84, p < .05\), and depression, \(F(4,71) = 12.51, p < .001\), scores all yielded significant group effects. In general, there was a tendency toward progressively increasing psychopathology across normal-eater women, nonabused bulimic women, bulimic women abused in childhood, and bulimic women abused during both childhood and adulthood. Group comparisons (using the Student–Newman–Keuls tests) indicated that the two abused bulimic groups displayed higher levels of impulsivity than did the two normal-eater groups. Bulimic groups displayed significantly higher levels of depression than normal-eater groups. In contrast, dissociation seemed to be especially characteristic of the BN/child and adult abuse group.

A series of univariate ANOVAs also revealed significant group effects for 13 of the 18 subscales of the DAPP (Table 2). Group comparisons showed normal-eater versus bulimic group differences for the following subscales: cognitive distortion, \(F(4,71) = 9.16, p < .001\); anxiousness, \(F(4,71) = 13.24, p < .001\); affective instability, \(F(4,71) = 15.43, p < .001\); self-harming behaviors, \(F(4,71) = 7.1, p < .001\); suspiciousness, \(F(4,71) = 9.42, p < .001\); insecure attachment, \(F(4,71) = 5.62, p < .01\); social avoidance, \(F(4,71) = 7.47, p < .001\); narcissism, \(F(4,71) = 8.16, p < .001\); identity problems, \(F(4,71) = 16.07, p < .01\); and passive aggressiveness, \(F(4,71) = 10.28, p < .01\). Although they also yielded significant group effects, restricted expression, \(F(4,71) = 6.69, p < .01\); conduct problems, \(F(4,71) = 4.03, p < .01\); and submissiveness, \(F(4,71) = 6.95, p < .001\), revealed a different pattern. Women in the BN/child and adult abuse group displayed higher levels of restricted expression and conduct problems than did the two normal-eater groups. In
Table 1. Mean ± SD scores for BN subgroups

<table>
<thead>
<tr>
<th></th>
<th>Control/No Abuse (N = 15)</th>
<th>Control/Child Abuse (N = 10)</th>
<th>BN/No Abuse (N = 11)</th>
<th>BN/Child Abuse (N = 25)</th>
<th>BN/Child and Adult Abuse (N = 15)</th>
<th>Univariate ANOVA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of objective binging episodes/month</td>
<td>0.00 ± 0.00</td>
<td>0.00 ± 0.00</td>
<td>38.36 ± 34.77</td>
<td>24.68 ± 29.37</td>
<td>37.13 ± 35.42</td>
<td>1.03</td>
</tr>
<tr>
<td>Number of vomiting episodes/month</td>
<td>0.00 ± 0.00</td>
<td>0.00 ± 0.00</td>
<td>43.90 ± 38.81</td>
<td>33.53 ± 37.46</td>
<td>71.17 ± 86.47</td>
<td>1.73</td>
</tr>
<tr>
<td>EAT-26 total score</td>
<td>3.13* ± 3.18</td>
<td>2.12* ± 2.07</td>
<td>44.64* ± 7.88</td>
<td>36.93b ± 10.98</td>
<td>40.92b ± 11.39</td>
<td>75.73***</td>
</tr>
</tbody>
</table>

Note: Means with different superscripts differ at the p < .05 level. BN = bulimia nervosa; ANOVA = analysis of variance; EAT-26 = 26-item Eating Attitude Test. 
***p < .001, **p < .01, *p < .05.
Table 2. Mean ± SD scores for BN and control subgroups

<table>
<thead>
<tr>
<th></th>
<th>Control/No Abuse (N = 15)</th>
<th>Control/Child Abuse (N = 10)</th>
<th>BN/No Abuse (N = 11)</th>
<th>BN/Child Abuse (N = 25)</th>
<th>BN/Child and Adult Abuse (N = 15)</th>
<th>Univariate ANOVA F (4,71)</th>
</tr>
</thead>
<tbody>
<tr>
<td>BIS total score</td>
<td>2.04&lt;sup&gt;a&lt;/sup&gt; 0.32</td>
<td>1.98&lt;sup&gt;a&lt;/sup&gt; 0.30</td>
<td>2.31&lt;sup&gt;b&lt;/sup&gt; 0.38</td>
<td>2.36&lt;sup&gt;b&lt;/sup&gt; 0.36</td>
<td>2.46&lt;sup&gt;b&lt;/sup&gt; 0.43</td>
<td>4.65**</td>
</tr>
<tr>
<td>DES total score</td>
<td>5.78&lt;sup&gt;a&lt;/sup&gt; 0.38</td>
<td>5.38&lt;sup&gt;b&lt;/sup&gt; 9.30</td>
<td>14.64&lt;sup&gt;b&lt;/sup&gt; 14.82</td>
<td>10.29&lt;sup&gt;b&lt;/sup&gt; 10.07</td>
<td>13.17&lt;sup&gt;b&lt;/sup&gt; 13.67</td>
<td>2.84*</td>
</tr>
<tr>
<td>CES-D total score</td>
<td>8.53&lt;sup&gt;a&lt;/sup&gt; 0.65</td>
<td>10.00&lt;sup&gt;a&lt;/sup&gt; 10.38</td>
<td>26.18&lt;sup&gt;b&lt;/sup&gt; 16.52</td>
<td>28.87&lt;sup&gt;b&lt;/sup&gt; 10.84</td>
<td>34.27&lt;sup&gt;b&lt;/sup&gt; 16.54</td>
<td>12.51***</td>
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<td>DAPP</td>
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<tr>
<td>Rejection</td>
<td>2.41 0.56</td>
<td>2.23 0.38</td>
<td>2.97 0.82</td>
<td>2.73 0.87</td>
<td>2.25 0.85</td>
<td>1.77</td>
</tr>
<tr>
<td>Compulsivity</td>
<td>3.11 0.64</td>
<td>3.33 0.72</td>
<td>3.90 0.76</td>
<td>3.32 0.90</td>
<td>3.67 1.07</td>
<td>1.85</td>
</tr>
<tr>
<td>Callousness</td>
<td>1.78 0.55</td>
<td>1.70 0.40</td>
<td>2.08 0.54</td>
<td>1.99 0.44</td>
<td>2.07 0.55</td>
<td>1.50</td>
</tr>
<tr>
<td>Stimulus-Seeking</td>
<td>2.39 0.76</td>
<td>2.29 0.55</td>
<td>2.96 0.86</td>
<td>2.74 0.90</td>
<td>3.17 1.04</td>
<td>2.36</td>
</tr>
<tr>
<td>Social Avoidance</td>
<td>2.08&lt;sup&gt;a&lt;/sup&gt; 0.65</td>
<td>2.09&lt;sup&gt;b&lt;/sup&gt; 0.86</td>
<td>2.93&lt;sup&gt;b&lt;/sup&gt; 1.17</td>
<td>3.15&lt;sup&gt;b&lt;/sup&gt; 0.99</td>
<td>3.57&lt;sup&gt;b&lt;/sup&gt; 0.82</td>
<td>7.47***</td>
</tr>
<tr>
<td>Narcissism</td>
<td>2.55&lt;sup&gt;a&lt;/sup&gt; 0.76</td>
<td>2.54&lt;sup&gt;b&lt;/sup&gt; 0.58</td>
<td>3.78&lt;sup&gt;b&lt;/sup&gt; 1.16</td>
<td>3.51&lt;sup&gt;b&lt;/sup&gt; 0.76</td>
<td>3.74&lt;sup&gt;b&lt;/sup&gt; 0.65</td>
<td>8.16***</td>
</tr>
<tr>
<td>Identity Problems</td>
<td>1.70&lt;sup&gt;a&lt;/sup&gt; 0.78</td>
<td>1.70&lt;sup&gt;b&lt;/sup&gt; 0.54</td>
<td>3.27&lt;sup&gt;b&lt;/sup&gt; 1.31</td>
<td>3.38&lt;sup&gt;b&lt;/sup&gt; 0.86</td>
<td>3.81&lt;sup&gt;b&lt;/sup&gt; 0.99</td>
<td>16.07**</td>
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<tr>
<td>Passive Aggressiveness</td>
<td>1.85&lt;sup&gt;a&lt;/sup&gt; 0.47</td>
<td>1.86&lt;sup&gt;b&lt;/sup&gt; 0.58</td>
<td>2.82&lt;sup&gt;b&lt;/sup&gt; 1.07</td>
<td>2.92&lt;sup&gt;b&lt;/sup&gt; 0.79</td>
<td>3.23&lt;sup&gt;b&lt;/sup&gt; 0.76</td>
<td>10.28**</td>
</tr>
<tr>
<td>Restricted Expression</td>
<td>2.12&lt;sup&gt;a&lt;/sup&gt; 0.72</td>
<td>2.31&lt;sup&gt;b&lt;/sup&gt; 0.70</td>
<td>3.04&lt;sup&gt;b&lt;/sup&gt; 0.71</td>
<td>2.89&lt;sup&gt;b&lt;/sup&gt; 0.78</td>
<td>3.46&lt;sup&gt;c&lt;/sup&gt; 0.95</td>
<td>6.69**</td>
</tr>
<tr>
<td>Conduct Problems</td>
<td>1.35&lt;sup&gt;b&lt;/sup&gt; 0.32</td>
<td>1.27&lt;sup&gt;b&lt;/sup&gt; 0.23</td>
<td>1.83&lt;sup&gt;b&lt;/sup&gt; 0.53</td>
<td>1.64&lt;sup&gt;b&lt;/sup&gt; 0.51</td>
<td>1.99&lt;sup&gt;b&lt;/sup&gt; 0.85</td>
<td>4.03**</td>
</tr>
<tr>
<td>Submissiveness</td>
<td>2.11&lt;sup&gt;a&lt;/sup&gt; 0.73</td>
<td>2.26&lt;sup&gt;b&lt;/sup&gt; 0.57</td>
<td>2.73&lt;sup&gt;b&lt;/sup&gt; 0.91</td>
<td>2.96&lt;sup&gt;b&lt;/sup&gt; 0.15</td>
<td>3.46&lt;sup&gt;c&lt;/sup&gt; 0.99</td>
<td>6.95***</td>
</tr>
<tr>
<td>Intimacy Problems</td>
<td>1.77 0.59</td>
<td>1.76 0.43</td>
<td>1.89 0.57</td>
<td>2.57 0.94</td>
<td>3.30 0.95</td>
<td>3.35</td>
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<tr>
<td>Cognitive Distortion</td>
<td>1.57&lt;sup&gt;a&lt;/sup&gt; 0.43</td>
<td>1.62&lt;sup&gt;b&lt;/sup&gt; 0.50</td>
<td>2.48&lt;sup&gt;b&lt;/sup&gt; 1.20</td>
<td>2.43&lt;sup&gt;b&lt;/sup&gt; 0.79</td>
<td>3.12&lt;sup&gt;b&lt;/sup&gt; 0.89</td>
<td>9.16***</td>
</tr>
<tr>
<td>Anxiety</td>
<td>2.29&lt;sup&gt;a&lt;/sup&gt; 1.00</td>
<td>2.14&lt;sup&gt;b&lt;/sup&gt; 0.62</td>
<td>3.87&lt;sup&gt;b&lt;/sup&gt; 1.17</td>
<td>3.71&lt;sup&gt;b&lt;/sup&gt; 0.77</td>
<td>4.01&lt;sup&gt;b&lt;/sup&gt; 0.99</td>
<td>12.34**</td>
</tr>
<tr>
<td>Affective Instability</td>
<td>2.33&lt;sup&gt;a&lt;/sup&gt; 0.80</td>
<td>2.06&lt;sup&gt;b&lt;/sup&gt; 0.58</td>
<td>3.91&lt;sup&gt;b&lt;/sup&gt; 1.09</td>
<td>3.47&lt;sup&gt;b&lt;/sup&gt; 0.80</td>
<td>3.98&lt;sup&gt;b&lt;/sup&gt; 0.71</td>
<td>15.43***</td>
</tr>
<tr>
<td>Self-Harming Behaviors</td>
<td>1.09&lt;sup&gt;a&lt;/sup&gt; 0.17</td>
<td>1.35&lt;sup&gt;b&lt;/sup&gt; 0.59</td>
<td>2.48&lt;sup&gt;b&lt;/sup&gt; 1.23</td>
<td>2.22&lt;sup&gt;b&lt;/sup&gt; 1.23</td>
<td>2.72&lt;sup&gt;b&lt;/sup&gt; 1.23</td>
<td>7.09***</td>
</tr>
<tr>
<td>Suspiciousness</td>
<td>1.53&lt;sup&gt;a&lt;/sup&gt; 0.31</td>
<td>1.60&lt;sup&gt;b&lt;/sup&gt; 0.36</td>
<td>3.09&lt;sup&gt;b&lt;/sup&gt; 1.00</td>
<td>2.54&lt;sup&gt;b&lt;/sup&gt; 0.95</td>
<td>3.16&lt;sup&gt;b&lt;/sup&gt; 1.31</td>
<td>9.42***</td>
</tr>
<tr>
<td>Insecure Attachment</td>
<td>2.07&lt;sup&gt;a&lt;/sup&gt; 0.62</td>
<td>1.88&lt;sup&gt;b&lt;/sup&gt; 0.76</td>
<td>3.13&lt;sup&gt;b&lt;/sup&gt; 1.18</td>
<td>2.82&lt;sup&gt;b&lt;/sup&gt; 0.98</td>
<td>3.22&lt;sup&gt;b&lt;/sup&gt; 0.99</td>
<td>5.62**</td>
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**p < .001. *p < .01. *p < .05.
addition, these women also reported that they were significantly more submissive than the nonabused bulimic women.

**DISCUSSION**

In our sample, we found reported rates of sexual and physical abuse in childhood among bulimic and nonbulimic women to be comparable to those obtained in previous reports (Calam & Slade, 1989; Connors & Morse, 1993). Similarly, rates for abuse in adulthood for bulimic women also resembled those reported in previous studies (Dansky et al., 1997).

Abuse in adulthood without childhood abuse was very rare. In our study, only 1 bulimic woman experienced adulthood abuse without childhood abuse and none of our control women reported adult abuse without childhood abuse. A possible explanation for the concurrence of childhood and adult abuse experiences may be that effects of childhood abuse on personality or adaptive mechanisms could increase the risk of later abuse in adulthood. For example, abuse might cause individuals to feel deserving of mistreatment, and hence to accept abusiveness in later relationships. Another explanation may be that the co-occurrence of childhood and adulthood abuse might implicate inherent individual traits (e.g., impulsivity). Individual traits might heighten the probability of an individual's risk of being abused in the first place, which, if persistent, might also underlie the risk later in life. Yet a third explanation is possible. For example, if people remain in certain social strata in which an elevated risk of abuse exists (e.g., in economically disadvantaged situations), then persistent risk of abuse (in both childhood and adulthood) might be attributed to aspects of the social environment. Our data do not allow us to select from among these alternative explanations. However, it seems to be true that abuse in adult years can often signal the presence of an earlier abusive experience.

We found the combined presence of childhood and adulthood abuse to be associated with elevations on certain psychological dimensions, especially dissociation and submissiveness. These results could implicate the causal effects of childhood abuse on personality development or the influences of constitutional traits in heightening the risk for abuse or both. Our data do not allow us to ascertain which explanation is correct. However, they do indicate a correspondence between traits and experience that may be of clinical relevance. For example, whether traits are a cause or a consequence, or both, their presence would seem to indicate a need to work the "interpersonal stance" assumed by abuse survivors, in the interest of preventing further risk of abuse.

**REFERENCES**


