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CHILDHOOD ABUSE, BODY IMAGE DISTURBANCE, AND EATING DISORDERS

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Abstract—Studies have suggested that women who experience child sexual abuse are at risk for developing symptoms related to anorexia nervosa and bulimia. The purpose of the present study was to examine the relationships among childhood sexual and physical abuse, body image disturbance, and eating disorder symptomatology. Of 670 female college students screened for childhood abuse, 29 sexually abused, 32 physically abused, and 29 nonabused women completed measures of eating disorder symptoms, psychological factors thought to be related to eating disorders, and body image disturbance. Contrary to previous reports, there was no evidence that child sexual or physical abuse was associated with the development of body image disturbance. Furthermore, the results did not support the hypothesis that child sexual and physical abuse are related to eating disorder symptomatology. It is suggested that subjects who are victims of child sexual abuse and who are receiving psychotherapy manifest higher rates of a number of different types of psychopathology, including eating disorders.

Key Words—Body image disturbance, Eating disorders, Child sexual abuse, Child physical abuse.

INTRODUCTION

RESEARCH HAS INDICATED that adult females with a history of child sexual abuse have higher rates of sexual disturbance, depression, anxiety, fear, and suicidal ideas and behavior than nonabused women (Beitchman, Zucker, Hood, DaCosta, Akman, & Cassavia, 1992). Clinicians and theorists have suggested that another long-term effect of child sexual abuse is an increased risk of anorexia nervosa and/or bulimia. There are similarities between women with eating disorders and victims of child sexual abuse, including their gender, low self-esteem, powerlessness in relationships, substance abuse problems, depression, maladaptive coping patterns and defenses, and behavioral histories (Root & Fallon, 1988). Eating disorders and child sexual abuse have also been linked to body image disturbance, a sense of ineffectiveness, interpersonal distrust, and dysfunctional family systems (Finkelnbur & Browne, 1986; Johnson & Connors, 1987; Polivy & Herman, 1987).

Abusive sexual experiences in childhood are not likely to be the sole cause of anorexia or bulimia. Rather, as Calam and Slade (1989) have suggested, childhood sexual abuse may be one of many possible factors that can precipitate eating disturbances. For example, problems in family or opposite sex relationships may serve as an immediate trigger for the development of eating disorder symptoms. Calam and Slade noted that physical abuse may also be associated with eating disorders, since what is perceived to be the impact of sexual abuse could actually be viewed as one facet of a wider association between coercion or violence and eating problems.
The hypothesized relationship between childhood abuse and eating disorders has been empirically investigated in previous research. Of 10 published studies, 9 concluded that child sexual and/or physical abuse and eating disorders are associated (Bailey & Gibbons, 1989; Beckman & Burns, 1990; Bulik, Sullivan, & Rorty, 1989; Calam & Slade, 1989; Hall, Tice, Beresford, Wooley, & Hall, 1989; Oppenheimer, Howells, Palmer, & Chaloner, 1985; Palmer, Oppenheimer, Dignon, Chaloner, & Howells, 1990; Root & Fallon, 1988; Smolak, Levine, & Sullins, 1990). There are significant methodological problems with much of this research, however, including:

1. The lack of comparison groups (Bulik et al., 1989; Oppenheimer et al., 1985; Palmer et al., 1990; Root & Fallon, 1988);
2. Questionable reliability and validity of assessment instruments (Hall et al., 1989); and
3. Failure to report frequency, severity, and/or recency of abuse (Bailey & Gibbons, 1989; Beckman & Burns, 1990; Bulik et al., 1989; Calam & Slade, 1989; Oppenheimer et al., 1985; Palmer et al., 1990; Root & Fallon, 1988; Smolak et al., 1990).

To date, only one published study has failed to find a relationship between child sexual abuse and eating disorders (Finn, Hartman, Leon, & Lawson, 1986). Finn and colleagues' sample had very high base rates of sexual abuse (70%) and lifetime eating disturbance (82% having at least moderately abnormal eating patterns currently or in the past), which resulted in a high proportion of their sample (57%) having histories of both sexual victimization and some type of eating problem. Despite this co-occurrence, a history of sexual abuse was not predictive of eating disturbance, which indicates little covariance between these variables. However, Finn and colleagues used a sample of women who were all in psychotherapy, and the authors did not differentiate between childhood and adulthood sexual abuse experiences.

Several clinicians and theorists have proposed that sexual abuse and body image disturbance are related. Finkelhor (1984) suggested that any type of forced sex is likely to have at least a short-term negative impact on body image. Kearney-Cooke (1988) stated that body disturbances are developed by many women with a history of sexual abuse, which should be expected since the body is the site of the original trauma. Oppenheimer and colleagues (1985) found that sexually victimized women often have feelings of inferiority or disgust about their femininity and sexuality that may lead to concern about their body weight, shape, and size. Hall and colleagues (1989) noted that their sexually abused patients regularly evidenced marked disturbances in body image, even before the onset of their eating disorders, reporting that they saw themselves as fat, ugly, and unworthy in adolescence. Despite the suggestions of these authors, there is currently no empirical evidence to indicate that women who were sexually abused as children are at risk for developing a negative body image as a result of the abuse.

The present study was designed to examine the relationships among childhood sexual and physical abuse, body image disturbance, and eating disorder symptomatology within a nonclinical sample. Sexually abused subjects who reported receiving no physical abuse were identified, as were physically abused subjects who reported receiving no sexual abuse, and a control group of nonabused subjects. Based on previous theory and research, it was hypothesized that women who were sexually abused as children would have the highest rates of body image disturbance, eating disorder symptoms, and related symptomatology, followed by women who were physically abused as children. Nonabused women were expected to have the lowest rates of body image distortion, eating problems, and related symptomatology.

Subjects

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Materials

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Intercept
Subjects
Six hundred and seventy female college students enrolled in introductory psychology classes at Northern Illinois University were initially screened for the experiment. All subjects received extra credit for their participation. Subjects were selected to comprise three history of abuse groups: sexually abused before age 13 (SA group; \(n = 29\)), physically abused before age 13 (PA group; \(n = 32\)), and no history of abuse (NA group; \(n = 29\)). Subjects were selected for the SA group who reported no history of physical abuse and subjects were selected for the PA group who reported no history of sexual abuse. Subjects who reported no history of sexual or physical abuse comprised the NA group. Subjects reporting the most frequent and severe abusive experiences were first asked to participate in the study, and those reporting less frequent and severe abuse were then selected.

Materials

**Childhood History Questionnaire.** Subjects were screened by means of the Childhood History Questionnaire (CHQ; Milner, Robertson, & Rogers, 1990). The CHQ is a self-report measure used to assess an individual's history of sexual and physical child abuse. The CHQ consists of questions about the type, frequency, and perpetrator of various sexually abusive behaviors, physically abusive behaviors, and physical abuse sequelae that were experienced and/or observed before and/or after age 13. Two part scores of the CHQ were used as selection criteria for the experimental groups: sexual abuse (excluding exhibition/flashing) before age 13, and physical abuse sequelae before age 13. Only subjects who reported receiving at least one type of sexual abuse or physical abuse sequelae "rarely," "occasionally," "often," or "very often" on the CHQ were selected to participate in the study. Milner and colleagues (1990) and Gold (1991) have provided data on the reliability and validity of the CHQ.

**Body Image Detection Device.** The Body Image Detection Device (BIDD; Ruff & Barrios, 1986) was used to assess body image. This instrument has been commonly used by investigators to measure subjects' perceptions of their body parts (Cash & Brown, 1987). The apparatus was constructed from an overhead projector, three pieces of posterboard, and two pieces of wood, according to Ruff and Barrios' (1986) specifications. The BIDD projects a band of light onto a wall. The subject is asked to adjust the width of the light to estimate the sizes of particular body parts, and to subjectively appraise the normality of each body part. The BIDD was selected as the body image measure because it allows for the assessment of both the perceptual and attitudinal components of body image, and its reliability and discriminative ability have been established (Ruff & Barrios, 1986).

**The Bulimia Test.** The Bulimia Test (BULT; Smith & Thelen, 1984) is a 32-item multiple-choice questionnaire designed to reflect the Diagnostic and Statistical Manual (3rd ed.; American Psychiatric Association, 1980) criteria for bulimia. The BULT's predictive ability and test-retest reliability have been established in a nonclinical population (Smith & Thelen, 1984).

**The Eating Disorder Inventory.** The Eating Disorder Inventory (EDI; Garner, Olmsted, & Polivy, 1983) is a multiple-choice, 64-item measure. It consists of three subscales (Drive for Thinness, Bulimia, Body Dissatisfaction) that assess behavioral and symptomatic patterns of anorexia or bulimia and five subscales (Ineffectiveness, Perfectionism, Interpersonal Distrust, Interoceptive Awareness, Maturity Fears) that measure psychological factors presumably re-
lated to these disorders. The Body Dissatisfaction subscale is a measure of subjective feelings and beliefs about the shapes and sizes of certain body parts. The EDI has been shown to differentiate anorexic women from normal controls (Garner et al., 1983) and bulimic women from normal controls (Gross, Rosen, Leitenberg, & Willmuth, 1986). Internal consistency, criterion-related validity, and convergent and discriminant validity have been established for all subscales (Garner et al., 1983).

The Beck Depression Inventory. The Beck Depression Inventory (BDI; Beck, 1972) has 21 items related to symptoms of depression. The BDI emphasizes cognitive content but covers the major signs of depression, with 2 items pertaining to affect, 11 to cognition, 2 to overt behavior, 5 to somatic symptoms, and 1 to interpersonal symptoms. Although it was designed for use in clinical populations, it appears to have adequate validity when used in normal college student populations with a cutoff score of 7 to 9 indicating depression (Blumberger, Oliver, & McClure, 1978). Split-half reliability and test-retest reliability have been shown to be adequate (Beck, 1972; Miller & Seligman, 1973).

Procedure

In part one of the experiment, the subjects were screened for a history of child sexual and physical abuse with the CHQ, and they completed the BULIT, EDI, and BDI. Based on their CHQ responses, 90 subjects were called back to participate on an individual basis in the second part of the experiment. After the subject arrived for the experiment, the experimenter obtained height and weight measures, and demonstrated the operation of the BIDD apparatus. The subject estimated the size of her chest, waist, hips, thighs, and face by means of a diverging band of light that was recorded in millimeters. A body perception index score (Slade & Russell, 1973) was computed as follows: (perceived size/actual size) × 100. After the estimate of each body part, the subject provided a subjective rating of the body part using a 1 to 100 point scale, with 1 representing dimensions grossly below the norm for her age, sex, and height, 50 indicating average dimensions, and 100 signifying dimensions grossly above the norm. The subject then used the band of light to project her ideal sizes for each body part, and an ideal body perception index score was computed: (ideal size/actual size) × 100. Actual body part widths were then measured in millimeters with a wooden caliper, which the subject placed at the sites she used for her estimations. The widths of the subject's actual measurements were then drawn on paper and displayed to her, and she was told that the widths represented the dimensions of another woman in the experiment of approximately the same height and age. The subject was asked to rate each body part of the "other subject" using the 1 to 100 point scale, and a discrepancy index was derived: (subjective rating of self/subjective rating of "other") × 100. At the end of the session, the subject was interviewed about current or past dieting attempts, weight history (highest and lowest weights since age 18 and in the past 3 months), and date of last menstruation (to ensure that the groups did not differ from one another with regard to abdominal bloating, etc.).

RESULTS

Of the 670 college females screened for abuse with the CHQ, 41.6% reported no history of sexual or physical abuse before and after age 13. Subjects who reported childhood sexual or physical abuse that did not meet the criteria for inclusion in the study constituted 38.5% of the sample, with 0.5% reporting sexual abuse, 35.4% reporting physical abuse, and 2.7% reporting both sexual and physical abuse. Of the 19.9% of the subjects who did meet the inclusion criteria, the sex abused (PA) had a mean P(2.87) = 1 from one subject of ethnic group.

The most sexual fondness reported in intercourse was indicated by 37.9% of the remaining subjects. Grandfather, stepfather, stepbrother, and friend's boyfriend were indicated in less than one percent.

The most bone fractures were reported in bruises, welts, and bone fractures. The response of the subject's bone fractures was indicated by one percent.

Analyses of the data revealed no significant differences in the groups for the Beck depression scores or the BDI scores.

For each subject, the Beck depression score was entered into a multiple regression analysis to predict the BDI score. The regression analysis was significant, F(3, 666) = 12.1, p < .001. The unique contribution of each predictor was assessed by examining the change in the R square as each variable was entered into the equation. The variables entered into the equation included body dissatisfaction, objective body perception, subjective body perception, and discrepancy index. Each variable contributed significantly to the prediction of the BDI score, explaining an additional 9% of the variance.
inclusion criteria, 5.8% reported sexual abuse, 10.9% reported physical abuse, and 3.1% met the criteria for both types of abuse.

The sexually abused (SA) group had a mean age of 18.8 years ($SD = 1.4$), the physically abused (PA) group had a mean age of 18.6 years ($SD = 0.8$), and the nonabused (NA) group had a mean age of 18.3 years ($SD = 0.6$). The three groups did not differ significantly in age, $F(2,87) = 1.53, p > .05$. A chi-square test indicated that the groups did not differ significantly from one another in racial composition, $\chi^2(8) = 7.56, p > .05$, with 66.7% of the subjects Caucasian, 12.2% African American, 10.0% Hispanic, 6.7% Asian, and 4.4% other ethnic group.

The most common type of sexual abuse was a combination of inappropriate touching and sexual fondling, reported by 41.4% of the SA group. Of the remaining SA subjects, 27.6% reported inappropriate touching only, 13.8% reported sexual fondling only, 3.4% reported intercourse/rape only, and 13.8% reported inappropriate touching, sexual fondling, and intercourse/rape. The mean frequency of sexual abuse reported was 3.1 ($SD = 2.3$), with a response of "3" indicating a frequency of "often." The most common perpetrators, reported by 37.9% of the SA group, were neighbors, adult friends of the family, or babysitters. Of the remaining subjects, 20.7% indicated that the perpetrator was an uncle, 13.8% reported their father, stepfather, or adoptive father, 13.8% reported their brother, stepbrother, cousin, or friend's brother, 10.3% reported their grandfather, 3.4% reported their mother, and 3.4% indicated that a stranger was the perpetrator. Two of the SA subjects reported abuse by more than one perpetrator.

The most frequently reported type of physical abuse sequelae was bruises/welts (56.3% of the PA group). Of the other PA subjects, 15.6% reported cuts/scratches only, 18.8% reported bruises/welts and cuts/scratches, 3.1% reported bruises/welts and burns, 3.1% reported bruises/welts and bone fractures, and 3.1% reported bruises/welts, cuts/scratches, dislocations, and bone fractures. The mean frequency of physical abuse reported was 2.0 ($SD = 1.3$), with a response of "2" indicating a frequency of "occasionally." The modal perpetrator was the father, reported by 65.6% of the PA subjects. The mother was reported by 56.3%, and the grandmother was reported by 3.1% of the group. Eight PA subjects reported abuse by more than one perpetrator. The nonabused group did not report any type of sexual or physical abuse.

### Analyses of Variables Related to Eating Disorders

In order to ensure that differences between the groups on the dependent measures were not attributable to differences on other variables related to eating disorders, separate between-subjects analyses of variance were conducted for the following variables: height, weight, highest adult weight, lowest adult weight, highest weight in the past 3 months, lowest weight in the past 3 months, percentage overweight, number of days since last menstruation, frequency of self-induced vomiting as reported on question 15 of the BULIT, and scores on the Beck Depression Inventory. There were no significant differences between the history of abuse groups on any of these variables. The largest $F$ value was $F(2,87) = 2.81, p > .05$ for scores on the Beck Depression Inventory. Chi-square analyses based on subject self-report indicated that there were no significant differences between the history of abuse groups, $\chi^2(2) = 3.23, p > .05$, with regard to whether or not they reported a childhood history of obesity. Of the entire sample, 38.9% reported a history of childhood obesity. In addition, there were no significant differences between the groups, $\chi^2(2) = 2.23, p > .05$, with regard to whether or not they reported currently being on a diet. Of the entire sample, 31.1% reported that they were currently dieting.

For each subject, a mean body perception index (BMI) was calculated by averaging her body perception index scores for the five body parts. The mean BMI was 114.4, 123.7, and 118.9
Table 1. Group Means (Standard Deviations) on the Perfectionism and Interoceptive Awareness Subscales of the EDI

<table>
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<tr>
<th>Group</th>
<th>Perfectionism</th>
<th>Interoceptive Awareness</th>
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<tbody>
<tr>
<td>SA</td>
<td>4.24 (4.92)</td>
<td>5.59 (4.17)</td>
</tr>
<tr>
<td>PA</td>
<td>5.81 (7.17)</td>
<td>8.81 (5.42)</td>
</tr>
<tr>
<td>NA</td>
<td>2.28 (3.35)</td>
<td>6.45 (4.05)</td>
</tr>
</tbody>
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for the SA, PA, and NA groups, respectively. An analysis of variance indicated that the groups did not differ significantly from one another in mean BPI scores, $F(2, 87) = 1.59, p > .05$. In addition, separate univariate analyses of variance conducted with the BPI scores for each of the five body parts revealed no significant differences between groups ($p > .05$).

Additional composite indices of body disturbance were derived. A composite ideal body perception index was computed by averaging the subject's ideal body perception index scores across body parts. A composite subjective self rating index was derived by averaging the subject's subjective ratings of her body parts, and a composite subjective other rating index was derived by averaging the subject's subjective ratings of the "other person's" body parts. A composite subjective self-other index was obtained by dividing the subject's self ratings by her "other" ratings for each body part and averaging these values. Finally, a composite BIDD-ideal index was calculated by dividing the subject's perceived sizes by her ideal sizes for each body part and averaging these values.

Five separate univariate analyses of variance were conducted with composite ideal BPI, composite subjective self rating index, composite subjective other rating index, composite subjective self-other index, and composite BIDD-ideal index as dependent variables. None of the differences between abuse history groups were statistically significant ($p > .05$).

Fifteen separate univariate analyses of variance were conducted for the BULIT total score, for the five subscales of the BULIT, for the EDI total score, and for the eight subscales of the EDI as dependent variables. Significant differences between groups were obtained only for two subscales of the EDI: Perfectionism, $F(2, 87) = 3.20$, $p < .05$, and Interoceptive Awareness, $F(2, 87) = 4.03$, $p < .03$. Table 1 presents the group means and standard deviations for these subscales.

Newman-Keuls tests indicated that the only significant difference ($p < .05$) on the Perfectionism subscale was between the PA and NA groups, and the only significant difference on the Interoceptive Awareness subscale was between the PA and SA groups. It should be noted that there were no significant differences between groups on the Body Dissatisfaction subscale of the EDI, indicating that the subjects' appraisals of their body parts were equivalent.

**DISCUSSION**

The hypothesis that sexual abuse is associated with the development of body image disturbances was not supported by the results. The finding that there were no differences between the history of abuse groups with regard to degree of body size overestimation and body dissatisfaction contradicts clinical observations reported in the literature (e.g., Halé et al., 1989; Kearney-Cooke, 1988; Oppenheimer et al., 1985). This finding also casts doubt on the hypothesized link between sexual abuse and eating disorder symptomatology, since a body image disturbance is generally assumed to be associated with the development of eating disorders.
Furthermore, the results do not support the hypothesis that there is a relationship between sexual abuse and symptomatology associated with eating disorders. The findings suggest only that physically abused subjects may set higher personal expectations for their achievement (as indicated by scores on the Perfectionism subscale of the EDI) than nonabused subjects, and have greater difficulty identifying emotions and sensations of hunger or satiety (as indicated by scores on the Interoceptive Awareness subscale of the EDI) than sexually abused subjects.

Finn and colleagues (1986) also concluded that subjects with sexual abuse histories were not more likely to develop eating disorders. This conclusion, however, contrasts with several studies that report a relationship between sexual abuse and eating disorders. Many of these studies (i.e., Bulik et al., 1989; Hall et al., 1989; Oppenheimer et al., 1985; Palmer et al., 1990; Root & Fallon, 1988) assessed a clinical population of subjects with eating disorders for histories of sexual abuse. One explanation for the different findings may be that subjects in an eating disordered clinical population have experienced more frequent or severe childhood sexual abuse than a nonclinical sample, and therefore may evidence higher rates of eating disorders as well as other types of psychopathology. By selecting subjects based on reported history of abuse who are not in treatment for eating disorders, subjects with a greater range of abuse and abuse sequelae may be studied.

In general, the results of the present study and of the other research reviewed suggest that the development of an eating disorder may be one detrimental effect of sexual abuse, but it is not the only type of psychopathology that sexual abuse victims experience. Furthermore, as Finn and colleagues (1986) suggested, the frequent co-occurrence of sexual abuse and eating disorders found in clinical samples may be attributable to high base rates of both sexual victimization and eating disturbance in the population of female therapy clients. These variables may simply be correlated rather than causally related.

There were several limitations of the present study. First, the study did not control for emotional abuse. It is possible that certain forms of emotional abuse, such as being told that one is "fat" as a child, could have an effect upon body image distortion and levels of eating disorder symptoms.

Second, the rate of reported sexual abuse in this study (12.1%) was comparable to the rate (10.7%) found in Milner and colleagues' (1990) study, which also assessed abuse history with the CHQ. However, other studies with college students have obtained higher incidence rates of 18% (Pinkelhor, 1979) and 22% (Fromuth, 1983). Since the CHQ requires the respondent to remember abuse experiences that may have occurred many years in the past, some recall error is inevitable (Milner et al., 1990). It is also possible that subjects may be less likely to recall abuse occurrences when responding to a brief questionnaire like the CHQ rather than a more detailed measure that provides more retrieval cues for memories of abuse (Wyatt & Peters, 1986).

Third, the sample of subjects in the present study may not be representative of abuse victims, since they were functioning well enough to be attending a university. It is possible that a high level of distress resulting from sexual abuse experiences would interfere with an individual’s academic performance and ability to function independently (Calam & Slade, 1989).

Fourth, frequencies and severities of sexual and physical abuse may have been too low to reveal a relationship between abuse and eating disorders. For example, only 23% of the sexually and physically abused subjects reported a frequency greater than "occasionally." In addition, only 4 of the 29 sexual abused subjects reported intercourse/rape, and only 4 of the 32 physically abused subjects reported dislocations, burns, or bone fractures. The remaining subjects reported less severe types of abuse. With more stringent criteria for inclusion in the study, additional significant results may have been obtained. Furthermore, other dependent measures not included in this study, such as lifetime prevalence of eating disorder symptoms, may be related to abuse variables.
Clinicians should be aware that abuse victims who seek treatment may be those who experienced the most severe abuse and who currently evidence more severe psychopathology including, but not limited to, eating disorders. Based on the results of this study, it cannot be assumed that sexual or physical abuse is related to body image disturbance and eating disorders for the entire population of abused women. Rather, these relationships may exist for certain subgroups within this population, or they may not exist at all.

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REFERENCES


Résumé—Des études ont suggéré que les femmes ayant vécu des sévices sexuels au cours de l'enfance sont à risque de développer des symptômes en relation avec l'anorexie mentale et la boulimie. Le but de cette étude-ci a été d'analyser les relations existant entre un abus sexuel ou physique au cours de l'enfance, les troubles de l'image corporelle et la symptomatologie liée aux troubles alimentaires. Des 670 étudiantes féminines interrogées au sujet d'antécédents de maigrir au cours de l'enfance, 29 ayant été abusées sexuellement, 32 malfaisées et 29 n'ayant pas été abusées ont rempli les données concernant les symptômes liés aux troubles alimentaires, les facteurs psychologiques habituellement mis en rapport avec les troubles alimentaires et les troubles de l'image corporelle. Contrairement à des rapports précédents, aucun lien entre les antécédents de maigrir au cours de l'enfance et les troubles de l'image corporelle n'a pu être démontré. Qu'il plus est, les résultats n'ont pas soutenu l'hypothèse soutenant la relation entre les abus sexuels ou physiques au cours de l'enfance et les symptômes liés aux troubles alimentaires. Il est donc suggéré que les sujets, ayant été victimes d'abus sexuel au cours de l'enfance et suivant une psychoterpéutique manifestent un plus grand nombre de signes psychopathologiques différents, dont les troubles alimentaires.

Resumen—Los estudios han sugerido que las mujeres que sufren abuso sexual en la niñez son de alto riesgo para desarrollar síntomas relacionados con anorexia nerviosa y bulimia. El objetivo del estudio presente es examinar las relaciones entre abuso sexual y abuso físico, trastornos en la imagen corporal, y sintomatología de los desórdenes del comer. De 670 estudiantes femeninas universitarias encuestas para detectar abuso en la niñez, 29 abusadas sexualmente, 32 abusadas físicamente, y 29 mujeres no abusadas fueron evaluadas para medir síntomas del desorden del comer, factores psicológicos que se piensa están relacionados con los desórdenes del comer, y distorsión de la imagen corporal. Contrario a reportes anteriores, no hubo evidencia de que el abuso sexual o físico en la niñez estuviera asociado con el desarrollo de trastornos en la imagen corporal. Además, los resultados no apoyaron la hipótesis de que el abuso físico o sexual a los niños está relacionado con la sintomatología de los desórdenes del comer. Se sugiere que los sujetos que han sido víctimas de abuso sexual en la niñez y que están recibiendo psicoterapia manifestan mayores tasas en un número cada vez mayor de diferentes tipos de psicopatología, incluyendo los desórdenes del comer.