 Reported Sexual Abuse and Bulimic
Psychopathology Among Nonclinical Women: The
Mediating Role of Shame

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Abstract: Objective: Despite consistent evidence that a reported history of sexual abuse is
linked to later bulimic psychopathology, less is known about the psychological processes
that underpin this relationship. This study examines the hypothesis that shame acts as a
mediator in the link between reported sexual abuse and bulimic attitudes. Method: A non-
clinical sample of female undergraduates (N = 214) completed standardized measures of
experiences of sexual abuse, internalized shame, and bulimic psychopathology. Regression
analyses were used to test for the mediating role of shame. Results: The findings were
compatible with a model where levels of shame partially account for the relationship be-
tween any history of reported sexual abuse and bulimic psychopathology, but entirely ac-
count for the link between intrafamilial abuse and bulimic attitudes. Conclusions: The
experience of shame appears to be important in understanding the relationship between
reported sexual abuse and bulimic attitudes. Where individuals report a history of sexual
abuse, particularly intrafamilial abuse, it may be clinically useful to focus on shame as a
psychological consequence of that experience. © 2002 by Wiley Periodicals, Inc. Int J Eat

Key words: sexual abuse; shame; bulimia

INTRODUCTION

A reported history of sexual abuse is implicated in a number of psychopathologies,
including bulimic attitudes and behavior (Schecter, Schwartz, & Greenfield, 1987; Waller,
1991; Waller, Halek, & Crisp, 1993). It appears that the nature of any reported sexual
abuse is also important. For example, sexual abuse occurring before the age of 18, abuse
involving a family member, and abuse involving force are particularly associated with
bulimic attitudes and behavior (Calam & Slade, 1989; Waller, 1992; Wonderlich, Brew-
erton, Jocic, Dansky, & Abbott, 1997). This relationship seems to be best explained by a
model where sexual abuse impacts on psychological and social processes, which in turn render the individual vulnerable to the development of psychological symptoms (Rorty & Yager, 1996). However, the specificity of these links is not clearly understood. In particular, it is not clear which mediators predispose women to developing eating psychopathology rather than other disorders.

Advances in the literature suggest that it would be useful to consider shame as a potential mediator in the link between sexual abuse and bulimic attitudes and behavior (Silberstein, Striegel-Moore, & Rodin, 1987). Shame is a negative self-conscious emotion that centers on an awareness of how the (perceived) defective self may appeal to others, and an accompanying sense of the self as powerless, inferior, and unlovable (Kaufman, 1992; Lewis, 1987; Tangney, Wagner, & Gramzow, 1992). More specifically, pathological shame (i.e., shame associated with psychopathology) is conceptualized commonly as internalized shame (Cook, 1994; Kaufman, 1992). Internalized shame is believed to be related directly to experiential factors arising from chronic exposure to shameful situations, such as sexual abuse. Consequently, an individual’s identity becomes associated with feelings of inferiority, worthlessness, and self-contempt (Kaufman, 1992).

Both theory and research suggest that internalized shame may be one common emotional response to the experience of sexual abuse (Kaufman, 1992). For example, among a sample of 92 female inpatients in an alcohol treatment program, Playter (1990) found that a reported history of sexual abuse was associated with higher levels of internalized shame. Internalized shame has also been implicated independently in bulimic psychopathology. Findings from clinical and nonclinical populations of women demonstrate that higher levels of internalized shame are associated with increased levels of bulimic psychopathology (Cook, 1994; Murray, Waller, & Legg, 2000). Based on this evidence, it seems plausible to suggest that shame may play a mediating role in the link between sexual abuse and bulimic attitudes and behavior. Therefore, the aim of this study of nonclinical women was to establish the potential viability of a model where internalized shame acts as a mediator in the relationship between reported sexual abuse (including specific aspects of sexual abuse) and bulimic psychopathology.

**METHOD**

**Participants**

Two hundred and forty-eight female undergraduates were invited to take part in the research. They received no payment for participation. Two hundred and fourteen agreed to take part (response rate = 86.2%). Their mean age was 21.6 years (SD = 4.10; range = 17–40). All participants were informed that their responses were anonymous and were assured of complete confidentiality.

**Measures and Procedure**

Each woman completed a questionnaire booklet anonymously and returned it to the researcher, who was waiting nearby. The booklet consisted of three standardized questionnaires that assessed reported experiences of sexual abuse, bulimic psychopathology, and internalized shame. These were presented in the order given below.
Sexual Events Questionnaire-2

In the SEQ-2 (Calam, Griffiths, & Slade, 1997), sexual abuse was defined as any experience, from childhood to present day, that is perceived to be both unwanted and sexual. This somewhat broad definition of sexual abuse means that the SEQ-2 returns relatively high rates of reported abuse. This measure, based on an original interview by Russell (1983), consists of 14 items that describe a range of unwanted sexual events. Participants are asked to indicate either “Yes” or “No” to items concerning whether or not they had experienced any of a range of unwanted sexual events, including those involving physical force or a biologically close or distant relative. When answering in the affirmative, participants are asked to state the age at which they first experienced the event. The SEQ-2 yields four ratings. The first is a dichotomous variable, dividing the sample into those who report any occurrence of abuse and those who report no such experiences. The second and third dichotomous variables indicate whether the individual reports any history of abuse involving force (Items 5, 7, 12, and 13) or a family member (Items 9, 10, and 11). Finally, age at first reported sexual abuse is used as a dimensional variable.

Bulimia Test

The BULIT (Smith & Thelen, 1984) is a 32-item, multiple-choice scale that measures bulimic attitudes and behaviors. It yields one overall score, where higher scores indicate greater bulimic psychopathology. The BULIT has satisfactory test-retest reliability and appropriate construct validity when used with a nonclinical population of women (Smith & Thelen, 1984).

Internalized Shame Scale

The ISS (Cook, 1994) is a 30-item questionnaire that measures internalized shame. Twenty-four items incorporate phenomenological descriptions of internalized shame (i.e., “I feel like I am never quite good enough”) and six items are positively worded self-esteem items. Participants are asked to indicate on a 5-point scale (0 = Never to 4 = Almost always) the frequency with which they have such feelings. One overall internalized shame score is derived from the 24 negatively worded items. Higher scores indicate greater levels of internalized shame. The ISS has demonstrated good internal consistency and acceptable construct validity (Cook, 1994).

Statistical Analysis

In the first phase, Baron and Kenny’s (1986) regression approach (equivalent to a simple path analysis) was used to test the potential mediating role of shame in the relationship between any history of sexual abuse and bulimic psychopathology for the whole sample. This involves a combination of simple linear and planned stepwise regression analyses. In the second phase, only women who reported some form of sexual abuse were included in the analysis (N = 141). In this case, Baron and Kenny’s (1986) regression approach was used to assess the mediating role of shame in the relationship between specific characteristics of abuse and bulimic attitudes.

RESULTS

Group Characteristics

The 214 women had a mean ISS score of 33.1 (SD = 16.8; range 0–92) and a mean BULIT score of 62.0 (SD = 16.8; range = 34–141). These scores correspond with those
found in other nonclinical groups (Cook, 1994; Wertheim, 1989). One hundred and forty-one women (65%) reported some form of sexual abuse as measured by the SEQ-2. Sixty-six of these 141 women (46.8%) reported some experience of sexual abuse involving force and 25 women (17.7%) reported some experience of intrafamilial abuse. The mean age at first experience of reported abuse was 13.6 years (SD = 4.89; range = 2–33).

Shame as a Mediator Between Any Reported History of Sexual Abuse and Bulimic Attitudes

Initially, three simple linear regression analyses were used to determine the pattern of association between sexual abuse and bulimic attitudes (BULIT), sexual abuse and internalized shame (ISS), and internalized shame (ISS) and bulimic attitudes (BULIT). These analyses included the whole sample (N = 214). In the first analysis, a significant link was found between sexual abuse and BULIT scores (F = 10.90; p < .01; explained variance = 4.4%; beta = 0.22).

There was also a small but significant relationship between sexual abuse and ISS scores (F = 4.30; p < .05; explained variance = 1.5%; beta = 0.14). Finally, ISS scores significantly predicted BULIT scores (F = 76.8; p < .001; explained variance = 26.1%; beta = 0.51).

In the final step necessary to test the mediating role of shame in the relationship between sexual abuse and bulimic attitudes, a planned stepwise multiple regression analysis was used in order to determine whether initially removing the impact of ISS scores weakens the subsequent ability of sexual abuse to predict BULIT scores. Here, once the significant effect of the ISS had been controlled for, the association between a reported history of sexual abuse and BULIT scores had weakened. This was demonstrated by a drop in the level of significance, explained variance, and beta value from the levels reported above (F = 6.11; p < .02; explained variance = 1.8%; beta = 0.15). In accordance with Baron and Kenny (1986), the results support a model where internalized shame acts as a partial mediator in the relationship between a reported history of sexual abuse and bulimic attitudes in this nonclinical population of women.

Shame as a Mediator in the Relationship Between Specific Characteristics of Abuse and Bulimic Psychopathology

Within the subgroup of women reporting any sexual abuse (N = 141), simple linear regression analyses were initially carried out in order to determine the pattern of bivariate associations between the specific characteristics of abuse, shame, and bulimic attitudes. Age at first experience of sexual abuse did not predict bulimic attitudes (BULIT scores; F = 0.16; NS; explained variance = 0%) nor did the presence of any history of abuse involving force (F = 0.01; NS; explained variance = 0%). In contrast, the presence of any abuse involving a family member was associated with bulimic attitudes (BULIT scores; F = 6.30; p < .02; explained variance = 3.6%; beta = 0.20). Similarly, neither age at first experience of sexual abuse nor a history of abuse involving force was predictive of internalized shame (ISS scores; F = 0.27; NS; explained variance = 0%, and F = 0.01; NS; explained variance = 0%, respectively). However, a significant link was found between abuse involving a family member and internalized shame (F = 10.1; p < .02; explained variance = 6.1%; beta = 0.26). ISS scores were significantly associated with bulimic attitudes (F = 45.5; p < .001; explained variance = 24.1%; beta = 0.49). According to Baron and Kenny’s (1986) approach, the lack of association between age at first experience of abuse or abuse involving force with bulimic attitudes (BULIT scores) and shame (ISS scores)
means that it was not necessary to include these variables in subsequent analyses. Thus, only sexual abuse involving a family member was used in the final model testing.

In the final stage, a planned stepwise regression analysis was used to determine whether initially removing the impact of ISS scores weakens the subsequent ability of intrafamilial abuse to predict BULIT scores. In this case, once the significant effect of the ISS had been controlled for, the previously significant predictive power of intrafamilial abuse was no longer found ($F = 1.20$; NS; explained variance = 0.1%; beta = 0.08). Within this nonclinical sample of women, this finding is compatible with a model where internalized shame acts as a perfect mediator (Baron & Kenny, 1986) in the relationship between the experience of sexual abuse perpetrated by a family member and bulimic attitudes.

**DISCUSSION**

Findings from this study of a nonclinical sample of women suggest that shame plays an important, yet complex, role in the relationship between sexual abuse and bulimic psychopathology. Although a reported history of sexual abuse appears to be associated with internalized shame, the results are compatible with a model where the relationship between sexual abuse and bulimic attitudes is only partially accounted for by internalized shame. This may be explained by the fact that it is only the experience of intrafamilial abuse that seems to be associated with internalized shame and bulimic psychopathology.

The findings substantiate the view that internalized shame states may arise as a result of chronic exposure to certain shameful situations (i.e., intrafamilial sexual abuse), and that this shame has an impact on bulimic attitudes and behavior, at least in nonclinical women. These results are especially relevant to previous studies, which demonstrate high levels of reported sexual abuse histories (particularly intrafamilial abuse) in women suffering from bulimic psychopathology (Calam & Slade, 1989; Waller, 1992; Wonderlich et al., 1997). However, in light of the current findings, it would seem that relying on bivariate associations fails to reflect the complexity of this relationship. Consideration of the underlying psychological processes also appears to be important and may account for the differential impact of specific characteristics of sexual abuse on bulimic psychopathology.

Further research is needed to confirm and extend these findings. It is important to note that the use of cross-sectional data in the present study means that it is not possible to draw any firm conclusions about cause-effect relationships between the variables. However, the findings do suggest that the current model is potentially viable. Therefore, further research employing a prospective design is required in order to establish whether the relationships described above are in fact causal. It would also be useful to assess how intrafamilial abuse may result in internalized shame. One possible explanation is that the secrecy associated with intrafamilial abuse (particularly the strategies employed by the perpetrator for maintaining secrecy [Jehu, 1988, pp. 66-67]) has the impact of making the individual feel blame for the abuse, defective, and worthless. Furthermore, in contrast to previous research, the link among intrafamilial abuse, internalized shame, and bulimic attitudes does not appear to be a developmental issue (at least not in nonclinical women), as age at first experience of abuse was not related to bulimic attitudes. Further research is necessary to test whether the model described above best explains the link between sexual abuse and other forms of psychological symptoms in nonclinical women, or is unique to bulimic attitudes and behavior.
Although it is important that the findings from the present study can be generalized to clinical groups of women suffering from bulimia, they may be of some use in prevention programs. For example, one potential target for future educational programs might be to encourage a positive response to any disclosure of intrafamilial abuse. This might help to relieve the individual of feelings of shame which, if left unchecked, may render her or him vulnerable to the development of later eating problems.

REFERENCES