Sexual Abuse and Eating Disorders: A Review

Mary E. Connors
Wayne Morse
(accepted 27 March 1992)

Studies investigating a possible relationship between sexual abuse and eating disorders have reported highly discrepant results. Some variability can be accounted for by methodological issues including diagnostic criteria, study design, and assessment techniques. The heterogeneity of an eating disordered population, especially regarding the comorbidity of eating pathology and personality disorder, is also a factor. Overall results suggest that around 30% of eating disordered patients have been sexually abused in childhood, a figure that is relatively comparable to rates found in normal populations. For some patients there may be a direct link between sexual trauma and eating pathology, but in general sexual abuse is best considered a risk factor in a biopsychosocial etiological model of eating disorders. Complex associations between trauma, self-regulatory deficits, and psychopathology require further research. © 1993 by John Wiley & Sons, Inc.

In recent years clinicians as well as the general public have noted two phenomena that impact the lives of large numbers of women: eating disorders and sexual abuse. Research studies have attempted to clarify the possible relationship between sexual abuse in childhood and the development of an eating disorder, but the results of these investigations are quite diverse. In this paper we shall review this literature, point out some of the challenges in researching the area, and attempt to clarify the nature of the relationship between child sexual abuse and eating disorders.

CLINICAL POPULATIONS

Early case studies of eating disordered patients who reported a history of sexual abuse (Crisp, 1984; Goldfarb, 1987; Sloan & Leichner, 1986) stimulated interest in the possible correlation. Oppenheimer, Howells, Palmer, and Chaloner (1985) published the first larger scale study of 78 female eating disordered outpatients. Patients were

Mary E. Connors, Ph.D., is a core faculty member at the Illinois School of Professional Psychology, and is in private practice. Wayne Morse, M.A., M.Div., is a student at the Illinois School of Professional Psychology. Address reprint requests to Dr. Connors at 55 East Washington, Suite 2007, Chicago, IL 60602.


CCC 0276-3479/93/010001-11
consecutive admissions to a clinic who met DSM-III (American Psychiatric Association [APA], 1980) criteria for anorexia (36), bulimia (33), or both disorders at some point in their life (9). Patients completed a Sexual Life Events Questionnaire (adapted from Finkelhor, 1979), which defined sexual events as those occurring when the subject was under 13 years old and the other participant was over 16, or when the subject was between 13 and 16 and the other was at least 5 years older. Twenty-three subjects (29.5%) reported sexual events that fulfilled these original criteria. Noting that the criteria were overly restrictive, the authors found that 27 more patients (34.6%) reported other adverse sexual experiences, for a total of 50 patients out of 78 reporting coercive sexual events. They found no relationship between a history of abuse and the type of eating disorder diagnosed.

Finn, Hartman, Leon, and Lawson (1986) studied 87 women drawn from women’s therapy groups in three different settings. Sixty-two percent of the 140 women they originally approached completed the study, responding to their Sexual Abuse Screening Checklist, their Eating Patterns Questionnaire (EPQ), and a structured interview. The women were in treatment for a range of issues including but not restricted to eating disorders or sexual abuse. The authors assigned DSM-III diagnoses based on responses to the EPQ, and found that 18.3% met criteria for bulimia, and that no subjects were anorexic. Sixty-one women were classified as abused based on endorsement of at least one item on the Checklist and corroborating evidence in the interview; 26 subjects were not abused. There were no statistically significant differences between abused and control subjects in the prevalence of bulimia or less severe forms of eating disturbance, with approximately 48% of women in both groups engaging in abnormal eating. The authors note that both eating disturbance and sexual abuse had very high base rates in their sample, but that there was no meaningful association between the two.

In an eating disordered sample, Root and Fallon (1988) studied 172 women who were consecutive applicants to a bulimia treatment program. All but a few met DSM-III criteria for bulimia as well as a stricter study criterion of binging plus purging. Subjects answered yes or no to questionnaire items asking if they had been victims of rape, child sexual abuse or physical abuse, or battering in a relationship with a partner. Abuse issues were further explored in an interview. Sixty-six percent of the women had been physically victimized, with 28.5% reporting child sexual abuse. The authors suggest that the results of their study should be considered conservative, because of the many reasons for underreporting abuse. They conclude that bulimic women, more often than not, have a history of physical victimization, and that this victimization does not cause bulimia, in a simplistic fashion, but that such experiences contribute to a woman’s vulnerability to developing bulimia as a way to cope with anger, powerlessness, and depression following physical boundary violations.

Bulik, Sullivan, and Rorty (1989) investigated the family environment and abuse history of 35 women meeting DSM-III criteria for bulimia (29 subjects met DSM-III-R [APA, 1987] criteria). The authors used a semistructured interview to obtain data about sexual abuse. Ten subjects reported personal sexual abuse, and an additional two described father-sister incest, which the authors collapsed into a familial sexual abuse group (34.3% of the sample). No differences were found between abused and non-abused subjects on any subscales of the Eating Disorder Inventory (EDI; Garner, Olmstead, & Polivy, 1983). The authors noted that their prevalence rate seemed comparable to that of Oppenheimer et al. (1985), but suggested that the abuse endured by their sample, which tended to be repetitive and incestuous, may have been more severe.
Hall, Tice, Beresford, Wooley, and Hall (1989) assessed 158 consecutive first admissions to an inpatient eating disorders unit using clinical interviews. Patients met DSM-III-R criteria for bulimia or anorexia (N = 72) or were assigned to a mixed group that included patients with morbid obesity, depression, thought disorder, and physical conditions (N = 86). Fifty percent of the combined anorexic and bulimic patients had suffered sexual abuse, compared with 28% of the mixed group. Eighty-five percent of the abuse experienced by the eating disorders group occurred before age 17.

Steiger and Zanko (1990) reported on a very well controlled study of 73 eating disordered female outpatients whom they identified as anorexic restrictors, anorexic bingers, and bulimics with and without an anorexic history, using DSM-III-R criteria and history of symptomatic behavior. They utilized two control groups: one was a group of 21 women receiving in- or outpatient treatment, primarily for anxiety or affective disorders, and the other contained 24 normal controls comparable in age and free of eating disorders. Around 30% of the eating disordered women reported childhood sexual trauma on a self-report measure, compared with 33% of the psychiatric controls. The different eating disordered groups varied widely, with anorexic restrictors having the lowest rate (6%), and bulimics with no anorexic history having the highest rate (46%). Bulimics with an anorexic history reported 25% and anorexic bingers reported 42%. The normal controls had unusually low rates of abuse for any female population at 9%.

The authors suggest that sexual abuse is common in the histories of a female psychiatric population, eating disordered or not. They further state that within an eating disordered population, such histories are more frequently associated with bulimic symptomatology, and seem quite rare in anorexic restrictors.

Palmer, Oppenheimer, Dignon, Chaloner, and Howells (1990) extended their preliminary report (Oppenheimer et al., 1985) and described their extended series of 158 eating disordered outpatients. Eighty women were anorexic, according to DSM-III criteria, and 78 were bulimic. Forty-nine subjects (31%) reported childhood sexual abuse experiences that met the original Sexual Life Events Inventory criteria, and another 42 (27%) reported other unpleasant or coercive sexual events. There was no significant association between rates of abuse and the particular type of eating disorder, or between age of abuse and the diagnosis.

NONCLINICAL POPULATIONS

Calam and Slade (1989) administered the Eating Attitudes Test (EAT; Garner & Garfinkel, 1979) and the Sexual Events Questionnaire (Russell, 1983) to 130 female undergraduates. The return rate was between 65% and 75%. Twenty percent of the women had experienced unwanted events before age 14, with 13% reporting intrafamilial events. Overall 58% of subjects reported some form of unwanted sexual experience. The occurrence of sexual abuse was associated with higher scores on two global measures of eating disorder (EAT 26 and EAT 40), and the Dieting subscale of the EAT.

There were no significant differences for the Bulimia or Oral Control subscales. Differences in EAT scores between subjects reporting intrafamilial abuse and those without such experiences were analyzed. Although all the means were in the predicted direction, the only significant difference was in the scores on Dieting. Bulimia scores were not significantly different. The experience of sexual events involving force was associated with higher EAT scores on all dimensions except Oral Control. The only form of
unwanted sexual experience before age 14 that correlated with reported eating problems was sexual intercourse.

Bailey and Gibbons (1989) administered a questionnaire to 294 college students that included a listing of the DSM-III criteria for bulimia plus weekly binges to make the diagnosis. The rate of return was 99%. Students also had to answer yes or no to four questions inquiring about experiences of child sexual abuse or physical abuse, rape, or battery. Thirteen percent reported child sexual abuse, 11% rape, 8% battery, and 6% physical abuse. Of the four variables, only child physical abuse had a significant relationship with the diagnosis or severity of bulimia; sexual abuse was nonsignificant.

Beckman and Burns (1990) studied 340 female undergraduates using the Bulimia Test (BULIT; Smith & Thelan, 1984) and a modified version of Finkelhor’s (1979) Life Events Questionnaire. Subjects were classified as bulimic or nonbulimic on the basis of a BULIT cutoff score of 88, using DSM-III criteria. Forty-four women (13%) were designated as bulimic and 170 as nonbulimic. Significantly more bulimic women reported having a forced extrafamilial sexual experience after age 12 than nonbulimics, with 49% of bulimics reporting this, compared to 27% of nonbulimics. There were no differences in the two groups’ reports of intrafamilial abuse after age 12. The authors reported an overall prevalence of sexual abuse across groups of 66% (subjects responded positively to at least one question about sexual experiences). However, relatively small percentages of subjects reported intrafamilial abuse (8.3% bulimics and 4.8% of nonbulimics) or extrafamilial abuse before age 12 (7.5% and 10.8%). Forced extrafamilial experiences after age 12 were common, as noted above, as were childhood sexual experiences with a child or adult that could include nonforced peer experimentation (30.2% of bulimics and 28% of nonbulimics).

Smolak, Levine, and Sullins (1990) mailed questionnaires to undergraduates and reported data on 298 women. They used the EDI (Garner et al., 1983) and a detailed questionnaire on sexual abuse that included Finkelhor’s (1979) definitions of sexual encounter and also solicited further information about the experiences. Twenty-three percent of the sample reported a child sexual abuse experience (excluding peer experiences); however, the overall return rate was 39%. The abused group had significantly higher total EDI scores than the nonabused group, but there were no subscale differences. EDI scores were not related to ratings of severity of abuse, type of contact, or familiarity of the perpetrator. The authors noted that whereas their data only partially supported their hypothesis that victims of child sexual abuse were more likely than nonvictims to develop disturbed eating behaviors and attitudes, contextual influences such as parental reliability seemed important; abused women who rated their parents as unreliable seemed to have more difficulty than abused women with reliable parents.

**METHODOLOGICAL ISSUES**

Clearly these studies are reporting very divergent results, ranging from Finn et al. (1986) finding of no relationship between eating disturbance and sexual abuse to Root and Fallon’s (1988) suggestion that because 66% of their bulimic sample had been physically victimized, perhaps denial of abuse against women in our culture partially accounts for the lack of research documentation of its frequency and impact. Root and Fallon rightly point out an important problem in our society, but other issues seem to affect research findings in this area.
Diagnostic Criteria for Eating Disorders

As can be seen in Table 1, the diagnostic criteria used in the studies vary, with some diagnosing according to DSM-III and some utilizing DSM-III-R. Studies such as Root and Fallon’s (1988) were exclusively done on bulimics; others such as Hall et al.’s (1989) looked at anorexics and bulimics; Steiger and Zanko’s (1990) study refined diagnostic categories further into bulimics, anorexics, anorexic bingers, and bulimics with an anorexic history. The DSM-III-R criteria for bulimia nervosa, which require a frequency of two binge-purge episodes weekly for 3 months, are significantly more stringent than the DSM-III criteria for bulimia. Some lack of comparability across groups is likely because of this. Additionally, most studies used outpatients, but Hall et al. (1989) assessed DSM-III-R diagnosed inpatients, probably a more severe group, and found higher rates of sexual abuse than most other reports.

The three studies that assessed both anorexics and bulimics report conflicting data on possible differences between the two groups. Hall et al. (1989) and Palmer et al. (1990) describe no differences in rates of abuse between anorexics and bulimics, whereas Steiger and Zanko (1990) report extremely low rates in restricting anorexics (6%) and high rates in anorexic bingers (42%), with the two bulimic groups showing moderate ranges. It is possible that Steiger and Zanko (1990), assessing smaller groups using more refined diagnostic criteria, detected real differences between anorexics and bulimics that would not be apparent in more heterogenous groups. It is unclear how Hall et al. (1989) and Palmer et al. (1990) handled the diagnostic issue with patients who met criteria for both anorexia and bulimia. It is not possible to resolve this issue without further research, ideally using Steiger and Zanko’s system or a comparable way to group patients who have anorexic and bulimic features.

Assessment of Sexual Abuse

The accurate assessment of a history of sexual abuse presents major challenges to researchers. Sexual abuse should be defined in such a way as to exclude consensual sexual exploration with peers and to include all coercive sexual experiences in childhood. Palmer et al. (1990) attempted to use criteria based on Finkelhor’s (1979) work, which specifies criteria for the ages of victim and perpetrator. This definition attempts to exclude experiences with peers, but it also discounts coercive activities with older siblings, etc., who do not meet the age criteria. Palmer et al. (1990) found that although 31% of their population met their original criteria for child sexual abuse, an additional 27% reported unwanted sexual experiences beyond the primary definition, suggesting that the original definition was overly narrow. Sexual abuse may also be defined too broadly, as Beckman and Burns (1990) did; it is not surprising that they found an overall abuse rate of 66%, because they included experiences with peers.

A number of the studies reviewed have assessed traumatic experiences other than child sexual abuse, including physical abuse in childhood, rape, assault or near miss of assault, and battering in a relationship. When several categories are combined, as in Root and Fallon’s (1988) report of 66% of bulimics having histories of physical victimization, the totals can be quite high, but it is important to remember that this does not represent experiences exclusive to childhood.

The problem of false negatives is significant in the assessment of child sexual abuse, because a number of abuse survivors have repressed or dissociated their experiences to the point that they have amnesia for the events (Herman & Schatzow, 1987). Other
<table>
<thead>
<tr>
<th>Authors</th>
<th>Subjects</th>
<th>Diagnosed</th>
<th>Abuse Measure</th>
<th>Comparison Groups</th>
<th>Abuse Rates</th>
<th>Correlations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finn, Hartman, Leon, and Lawson (1986)</td>
<td>87 outpatients in group therapy</td>
<td>18% DSM-III bulimics by EPQ</td>
<td>Sexual Abuse Screening Checklist + interview</td>
<td>61 abused; 26 controls</td>
<td>N/A</td>
<td>No relationship between sex abuse and eating disturbance</td>
</tr>
<tr>
<td>Root and Fallon (1988)</td>
<td>172 outpatient bulimics</td>
<td>DSM-III criteria for bulimia + purging</td>
<td>BREDIS + yes or no to abuse + interview</td>
<td>None</td>
<td>28.5 CSA; 29% CPA; 23% battered 23% raped</td>
<td>N/A</td>
</tr>
<tr>
<td>Bulik, Sullivan, and Rorty (1989)</td>
<td>35 bulimics responding to ad</td>
<td>DSM-III criteria for bulimia; 29 met DSM-III-R</td>
<td>Interview</td>
<td>12 abused; 23 nonabused</td>
<td>29% CSA (90% of CSA was incest)</td>
<td>No difference between abused and nonabused on EDI</td>
</tr>
<tr>
<td>Hall, Tice, Beresford, Wooley, and Hall (1989)</td>
<td>158 ED inpatients</td>
<td>DSM-III-R criteria for AN and BN</td>
<td>Interview</td>
<td>16 AN; 56 BN; 86 mixed pathology</td>
<td>50% of ED patients abused; 28% of mixed group abused</td>
<td>N/A</td>
</tr>
<tr>
<td>Calam and Slade (1989)</td>
<td>130 undergrads (65–75% return rate)</td>
<td>EAT used; no diagnoses made</td>
<td>Sexual Events Questionnaire</td>
<td>None</td>
<td>29% CSA before 14; 58% some unwanted experience</td>
<td>Abuse corresponding with higher scores on EAT 26, EAT 40 subscales CPA but not CSA corresponding with bulimia</td>
</tr>
<tr>
<td>Bailey and Gibbons (1989)</td>
<td>294 female undergrads (99% return rate)</td>
<td>DSM-III criteria for bulimia + weekly binges</td>
<td>4 yes/no questions re abuse</td>
<td>8% classified as bulimia and compared to controls</td>
<td>13% CSA; 6% CPA; 8% battery; 11% rape</td>
<td></td>
</tr>
<tr>
<td>Study and Year</td>
<td>Sample</td>
<td>Measure</td>
<td>Method</td>
<td>Control Group</td>
<td>Abuse Rate</td>
<td>Note</td>
</tr>
<tr>
<td>---------------</td>
<td>--------</td>
<td>---------</td>
<td>--------</td>
<td>---------------</td>
<td>------------</td>
<td>------</td>
</tr>
<tr>
<td>Steiger and Zanko (1990)</td>
<td>73 ED outpatients</td>
<td>DSM-III-R criteria for AN, BN</td>
<td>Detailed questionnaire</td>
<td>16 AN; 12 AN/B; 25 BN; 20 BN + A; 21 mixed controls; 24 normals</td>
<td>5% of AN; 42% of AN/B; 24% of BN; 23% of BN + A; 33% of mixed; 9% of normals</td>
<td>N/A</td>
</tr>
<tr>
<td>Oppenheimer, Howells, Palmer, and Chaloner (1985); Palmer, Oppenheimer, Dignon, Chaloner, and Howells (1990)</td>
<td>158 ED outpatients</td>
<td>DSM-III criteria for bulimia and AN</td>
<td>Finkelhor + interview</td>
<td>80 AN; 78 bulimia</td>
<td>31% CSA by criterion; 27% other</td>
<td>No relation between diagnosis and abuse rate</td>
</tr>
<tr>
<td>Beckman and Burns (1990)</td>
<td>340 undergrads</td>
<td>BULIT score of 88 to diagnose DSM-III bulimia</td>
<td>Finkelhor (modified)</td>
<td>144 bulimics; 170 nonbulimics</td>
<td>Overall abuse 66%</td>
<td>More bulimics had extrafamilial abuse after age 12</td>
</tr>
<tr>
<td>Smolak, Levine, and Sullins (1990)</td>
<td>298 undergrads (39% return rate)</td>
<td>EDI used; no diagnoses made</td>
<td>Finkelhor (modified)</td>
<td>69 abused; 229 not</td>
<td>23%</td>
<td>Abused had higher EDI totals but no subscales</td>
</tr>
</tbody>
</table>

Note. AN = anorexia nervosa; BN = bulimia nervosa; CSA = child sexual abuse; CPA = child physical abuse; ED = eating disordered; EPQ = Eating Patterns Questionnaire; EAT = Eating Attitudes Test; EDI = Eating Disorder Inventory; BULIT = Bulimia Test. BREDIS = Bulimia and Related Eating Disorders Screen.
patients may have some degree of awareness of abuse, but may be reluctant to acknowledge it to themselves or to anyone else. Palmer et al. (1990) noted that some abused patients did not reveal their experiences until some months into their hospital stay. Abuse survivors who are just entering treatment, or college students not in treatment, might have less awareness of their experiences than patients who have had some time in the safety of a psychotherapy relationship to recover buried memories. Studies that utilized detailed questionnaires about abusive experiences and then followed up with an interview would probably be most effective in eliciting acknowledgments of abuse from those who remembered it. Bailey and Gibbons (1989), who found unusually low rates for sexual abuse in their sample, probably failed to detect some abuse victims by asking only a single yes/no question about sexual abuse. It is possible that the return rates for questionnaires in the other studies of college students were affected by abuse survivors' finding the questionnaire disturbing, whether they consciously remembered their experiences or not, and discarding it.

Several studies made efforts to distinguish between incestuous abuse and extrafamilial abuse, an important distinction because some literature suggests that incestuous abuse tends to have more serious consequences (Russell, 1986). However, overall the present studies found few differences between intra- and extrafamilial abuse as it related to severity of eating disturbance.

Study Design

The studies reviewed utilized two main strategies to assess the relationship between sexual abuse and eating disorders. Some primarily explored the prevalence of sexual abuse in the histories of a diagnosed eating disordered population, usually without any control group. Others began with a nondiagnosed population of college students or women in psychotherapy groups and correlated eating disturbance as measured by an instrument such as the EDI with any reported experiences of sexual abuse. Generally, it is the uncontrolled studies reporting prevalence rates of abuse in eating disordered women that seem to suggest the strongest link between the two. Overall prevalence rates for various eating disordered groups range from 6% to 66%, but the findings of several studies seem to cluster around a 30% rate for child sexual abuse.

The studies reviewed that looked for correlations between reported abuse and scores on measures of eating disturbance generally did not report a strong relationship. Finn et al. (1986) and Bailey and Gibbons (1989) found no relationship; Bulik et al. (1989) found no differences between abused and nonabused groups on EDI subscales; Smolak et al. (1990) found higher EDI totals but not subscale scores for abused subjects. Calam and Slade did find that abuse correlated with higher scores on EAT subscales. The correlational data might be taken as suggestive of a weak relationship between sexual abuse and eating disorders.

In the two studies using mixed psychiatric patients as controls, Steiger and Zanko (1990) reported the rates of abuse to be comparable (30% and 33%), and Hall et al. (1989) found that eating disordered patients had significantly higher rates of abuse (50% compared to 28%). These findings must be viewed in the context of rates of abuse reported in the general female population and in other psychiatric groups. Steiger and Zanko's (1990) report of a 9% abuse rate in their normal control group is unusually low. Finkelhor (1979) found that 19% of female college students had some sexual encounter with an adult during childhood, and estimated that 10% to 30% of all girls are sexually abused in childhood (Finkelhor, 1984). Russell (1986) reported that 16% of her
sample were victims of incestuous abuse before age 18. Further, 28% of subjects had at least one experience of sexual abuse prior to age 14, and 38% before age 18.

Reports of abuse in psychiatric populations are generally higher. Studies of inpatients with mixed diagnoses found figures ranging from 22% to 55% (Bryer, Nelson, Miller, & Krol, 1987; Chu & Dill, 1990; Jacobson, 1989), and a report on psychotic inpatients found 46% (Beck & van der Kolk, 1987). Studies of outpatients with mixed diagnoses found ranges between 42% and 56% (Coons, Bowman, Pellow, & Schneider, 1989; Jacobson, 1989; Strick & Wilcoxin, 1991). A study of patients with somatization disorder reported a 55% abuse rate (Morrison, 1989) and a report on borderline patients found 67% (Herman, Perry, & van der Kolk, 1989).

CONCLUSIONS

Finn et al. (1986) noted the high base rates of both eating disturbance and sexual abuse in their sample. The issue is whether a meaningful relationship exists between the two phenomena, or merely an illusory one because of the prevalence of both in a female population. It is clear from the data that child sexual abuse is neither necessary nor sufficient for the development of an eating disorder; however, in a number of cases it may be an important etiological factor. We might conclude from the studies reviewed here that around 30% of eating disordered patients have been sexually abused. This figure may be relatively comparable to that found in the general female population, and is lower than numbers found in some other psychiatric groups. However, the wide range of figures found across studies of various groups suggests the need for increased methodological rigor and caution in interpreting results.

Many clinicians have become interested in a potential link between sexual abuse and eating disorders because of their clinical experiences; we have seen quite a few patients who believed that they developed an eating disorder in part to cope with sexual abuse. For example, one anorexic patient quite consciously began to starve herself in order to be unappealing to her sexually abusive brother, and another patient developed anorexia after being forced to perform oral sex during a rape. Other patients have reported binge-eating with large weight gains that they found reassuring in assuaging their feelings of vulnerability following sexual predation.

For such patients, there may be a relatively direct link between sexual trauma and the development of an eating disorder. However, from data reviewed here it seems that sexual abuse has limited explanatory power for eating disorders in general. It might best be regarded as a risk factor in a multidimensional approach to the etiology of eating disorders. The biopsychosocial perspective (Johnson & Connors, 1987) states that biological, psychological/familial, and sociocultural factors combine in an additive fashion to produce eating pathology. An individual who might be biologically predisposed to affective dysregulation and may have a genetic loading for eating disturbance (Fichter & Noegel, 1990; Kendler et al., 1991; Pope, Hudson, Jonas, & Yurgelun-Todd, 1983) is doubly at risk growing up female in a culture that is obsessed with thinness for women and that stresses perfection and achievement while offering few realistic models. An optimal family experience could help modulate the impact of these two risk factors. However, we know that the families of eating disordered patients tend to have difficulty with boundaries, conflict management, and support for autonomy (Humphrey, 1987, 1989). In terms of deficits in family functioning that would predispose an individual to self-regulatory difficulties, sexual abuse may or may not be a factor.
Sexual abuse, particularly incestuous abuse, cannot be isolated from the context in which it occurs. Family systems that tolerate the perpetration of sexual abuse might also have high levels of addictive disorders, physical and emotional neglect and/or abuse, and other psychopathology. Deficits in the regulation of affect and self-esteem may result from one or more of these factors. An individual attempting to manage painful self-states in the absence of internalized calming abilities could turn to food, or to other impulsive behaviors, but the causal links are complex and multifaceted, rather than direct.

Further, eating disordered patients are a heterogeneous group. Not only do their symptomatic expressions vary between bing and restricting, with myriad combinations of the two, but they also are distributed along a continuum of psychopathology, ranging from "neurotic" patients free of personality disorder, to those with significant personality disorder, to very severely disturbed borderlines (Johnson & Connors, 1987; Wonderlich & Swift, 1990). The comorbidity of eating disorders and other concurrent pathology, particularly personality disorder, significantly complicates the attempt to isolate etiological factors in eating disorders. None of the studies reviewed here explored the prevalence of personality disorder in their samples, but it may be that variability in this factor is responsible for some of the divergent conclusions reached. Herman et al. (1989) suggest a strong relationship between early trauma and borderline personality disorder. The correlation between sexual trauma and general personality disturbance may turn out to be stronger than the relationship between trauma and eating pathology, which, like depression, anxiety, and substance abuse, is present across a wide range of personality functioning.

REFERENCES


