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# Body Image Dissatisfaction and Eating Behavior in Survivors of Child Sex Abuse

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Ellen S. Dorfman, B.S.W.

An Abstract Presented to the Faculty of the
Graduate School of Lindenwood College in Partial
Fulfillment of the Requirements for the
Degree of Master of Arts

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# ABSTRACT

A review of the literature suggests a relationship between child sexual abuse and the development of eating disorders in female subjects. Additionally, body image dissatisfaction and distortion are well documented among eating disordered individuals and women in general. This study found a relationship between body image dissatisfaction and some eating disordered behaviors. Women who are in out-patient therapy for treatment of child sexual abuse were surveyed. Secretiveness about the sexual abuse at the time of the abuse was compared to both body image dissatisfaction and eating disorder attitudes and behaviors. Secretiveness was signicantly related to body image disturbance but was unrelated to the other eating disorder scales.

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# Body Image Dissatisfaction and Eating Behavior In Survivors of Child Sexual Abuse

Ellen S. Dorfman, B.S.W.

A Culminating Project presented to the Faculty
of the Graduate School of Lindenwood College
in Partial Fulfillment of the Requirements for the
Degree of Master of Arts

1991

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# CHAPTER 1

# INTRODUCTION

Clinicians and researchers alike recognize that women who survive child sexual abuse can face a wide array of psychological challenges (Goodwin, Cheeves & Connell, 1990; Shearer, Peters, Quaytman & Ogden, 1990; McClelland, Mynors-Wallis, Fahy & Treasure, 1991; Gregory-Bills & Vincent 1989). Clinicians have noted (Goldfarb, 1987; Schecter, Schwartz & Greenfeld, 1987) that their clients who have been victimized sexually in childhood often struggle with eating disorders and related body image concerns. This writer has experience with both eating disordered and sexually abused populations and has noted that treating one condition often entails treating the other. Current research on this topic cautious in defining a relationship between sexual abuse and eating disorders.

The following literature review explores the relationship, or lack thereof, between eating disorders, body image dissatisfaction, and child sexual.This review is subdivided into two catagories: 1) the relationship between body image dissatisfaction and eating disorders (pathological

and normal), and 2) the relationship between eating disorders and child sexual abuse. This writer found no significant research specifically linking child sexual abuse and body image dissatisfaction, although the presence of dysfunctional body image seems to be an aspect of being a survivor of child sexual abuse. Therefore, studies linking body image dissatisfaction and child sexual abuse will be mentioned primarily in the context of child sexual abuse/eating disorders research.

## Purpose of This Study

This study investigated the relationship between eating disordered attitudes and self-reported behaviors and distorted body image in a sample of women who are currently in outpatient psychotherapy related to their child sexual abuse experiences. The research reviewed suggests that, body image disturbance is an important and reliable predictor of eating disordered attitudes and behaviors. Additionally, several investigators have noted an association between eating disorders and child sexual abuse. It is presumed that body image disturbance among child sexual abuse survivors would be a contributing factor to this

outcome, yet this writer found no studies which specifically addressed this possible connection. It is hypothesized that women who have suffered sexual invasion during developmentally formative years will evince a greater degree of body image disturbance which could manifest itself in eating disordered behavior and attitudes. As evidence of this, there should be a relationship between body dissatisfaction and eating disordered attitudes and behaviors in this sample.

Additionally, it is hypothesized that body dissatisfaction and eating disordered attitudes and behaviors will be related to whether or not the incest was kept secret by the survivor at the time she was being abused, as sugested by the research of Gregory-Bills and Vincent (1989).

# CHAPTER 2

# EATING DISORDERS AND BODY IMAGE DISTURBANCE

## Studies of Clinical Populations

In her study of body image disturbance among anorexic patients, Mirja Kallipuska (1982) used the Draw-A-Person test to study body image adequacy, disturbance, and faltering body image as well as hostility, regression, and ego identity problems. She found that anorexics differed from the control group in one significant way: anorexics showed much more disturbance of all three body image variables than their "normal" counterparts.

Williamson, Kelley, Davis, Ruggiero, and Blouin (1985) looked at various psychopathological symptoms in bulimic, obese, and normal subjects. They noted more general pathology in bulimic subjects than either obese or normal ones, although they found similar eating habits as well as similar levels of guilt, impulsivity, and obsessiveness in bulimic and obese subjects. Interestingly, their data suggest that distorted body image perceptions and a desire for a smaller body contributed strongly to the maintenance of eating disordered

behavior in bulimics.

In 1984, Katzman and Wolchik assessed several personality characteristics of bulimic and binge eaters (no purging) in a college student sample. Their correlational data revealed that bulimics tended to exhibit poorer body image, as well as lower self-esteem and higher depression than either binge eaters or the control group. However, Steiger, Fraenkel, and Leichner (1989), studying anorexic, bulimic, and normal women noted that anorexics had distorted images of their own bodies, while bulimics did not. Steiger et al (1989) also assert that actual body weight of an individual was the best predictor of body image disturbance in their sample.

Alternatively, Lindholm and Wilson (1988) tested the accuracy of body image assessment among bulimics, restrained eaters, and non-restrained eaters and found inaccuracy and body image disturbance in all three groups. Their analysis concludes that bulimics were in fact *more* accurate in their body size estimates than the other two groups. However, in terms of desired body size, bulimics and restrained eaters "wished to be

significantly smaller than they perceived themselves to be... 12 to 14% thinner than they actually were" (Lindholm & Wilson, 1988, p 534). As bulimics tested higher on scales of depression than the other two groups, the authors felt the accuracy outcome for bulimics might reflect depressive realism.

In an analysis designed to contribute to the discussion about recent revisions of the diagnostic criteria in the DSM-IIIR, Davis, Williamson, Goreczny, and Bennett (1989) attempted to distiguish between bulimics who purge (bulimia nervosa) and simple bulimics (non-purgers) by investigating body image disturbances in samples representing both groups as well as an obese control group. They indicated that bulimia nervosa subjects perceived themselves as having a larger current body size (relative to reality) than either of the other two groups. Additionally, purging bulimics chose ideal body sizes that were significantly smaller than those chosen by either of the other two groups.

In their investigation of body image distortion among eating disordered patients Seebach and Norris (1989) compared anorexic, bulimic, and

obese patients to a normal control group. They noted that the degree of distortion of body image by anorexics held true even when these patients were confronted with physical evidence to the contrary. Bulimics differed in this respect. At first their body image report was distorted but when they were confronted by real physical evidence of their own normal body size, they tended to view themselves more realistically. Obese women in their sample tended to maintain a more realistic body image throughout, one comparable to the outcome for normal women. They concluded that cognitive interventions in an eating disordered population should vary according to the type of eating disorder the patient displays.

Freeman, Beach, Davis, and Solyom (1985) attempted to predict relapse in bulimics following treatment. Six months after treatment they found that bulimics with high scores in body image disturbance were the subjects most likely to have relapsed into continued bulimic episodes (binge and purge). They identified another cognitive component featured in relapsing bulimics: "the morbid fear of becoming fat" (Freeman et al, 1985, p352).

Findings of several researchers indicated a relationship between eating disorders and substance addiction (Webbe & Clontz, 1989; Cooper 1989). Webbe and Clontz (1989) studied a large group who identified themselves as addicted to food. Their sample was obtained through Overeaters Anonymous, a self-help group which approaches eating disorders on the addiction model. This group was mostly composed of obese women who worried about their weight and ate in an out-of-control way, binging at least once daily. In this descriptive study 95% of the respondents reported poor self-and body-image. Cooper (1989) noted that chemically dependent persons and persons afflicted with eating disorders shared four characteristics including denial of the compulsion, uncontrollable self-destructive behavior, exacerbation of symptoms without treatment, and similar family of origin patterns.

## Studies of Normal Populations

The following studies generally examine eating behavior and body image among women who are essentially normal. Usually this means they are not members of identified patient samples and have not exhibited severe restricting, binging, or

purging behavior. In general when findings indicated eating behavior or body image disturbance, the authors credited these findings at least in part to current social norms which value slenderness at a level somewhat "thinner" than what is actually normal in the population. Most claim a higher prevalance of this attitude in younger populations.

From their normal college student sample Cash, Counts, and Huffine (1990) constructed three groups: those who were currently of normal weight and had always been so; those who were formerly overweight, but are currently normal weight; and those who are currently overweight. Among these groups overweight subjects had poorer self-and body images than their normal weight counterparts, but formerly overweight individuals continued to regard themselves as "fat" and compared most closely with the overweight group. The authors concluded that weight loss in and of itself does not guarantee improved body image, citing body dissatisfaction as a prime indicator of relapse potential, replicating Freeman et al´s (1985) findings in their clinical sample. Thompson (1986) cites this and other research in a popularized version of his findings

published in _Psychology Today_. Contrary to some research in the clinical sample section of this paper, he noticed that bulimics overestimate body image even more than do anorexics. However, his crucial point was that that all women are prey to inaccuracy in their perception of body image.

In a large (n= 677) college student sample, Basow and Schneck (1983) found that about 13% of respondents could be classified eating disordered or nearly so according to their responses to the questionnaire administered. While they found distorted attitudes towards eating and body image in the entire sample, those classified as eating disordered were more depressed, had lower self-esteem, and were somewhat more likely to overestimate their own body size.

Klemchuk, Hutchinson, and Frank (1990) in advocating the use of the _Eating Disorders Inventory_ (Garner, 1990) in non-clinical populations administered this instrument to a large and widespread sample of female undergraduates (n = 1,506). The most significant finding in this study identified a very high level of body dissatisfaction throughout this non-clinical sample.

In their examination of personality as a predictor of binge eating and weight, Wolf and Crowther (1983) identify preoccupation with food, concern about dieting, fear of loss of control, and increased body image dissatisfaction as good predictors of increased binge eating. Alternatively weight and binge eating were found to be almost totally independent of each other. These authors noted a very strong relationship between anorexic-like attitudes, negative body image, and binge eating behavior.

In a specific study of perceptual distortion of body image in non-eating disordered women, Birtchnell, Dolan, and Lacey (1987) indicated that normal weight women overestimated their own body size, but that they did so to a lesser degree than eating disordered women. These authors faulted cultural expectation of slenderness for the wide prevelance of perceptual distortion. Another article by the same authors (Dolan, Birtchnell & Lacey, 1987), tested body perceptions in both male and female non-clinical populations. Not surprisingly, men in this sample were more satisfied with their body weight than were female subjects and reported fewer distorted self-

perceptions.

Eating Disorders and Surviving Child Sexual Abuse

An interesting facet of the results in the literature on this topic is the wide variety of findings in terms of relationship. Conclusions in the research vary from very strong to much weaker relationships between these two variables. This review organizes the available research from most relationships found to least relationships found, in the hope that the reader will appreciate the subjective and elusive nature of the data.

A hypothesis of significant relationship between unwanted sexual experience and eating problems was confirmed in a non-clinical female undergraduate population by Calam and Slade (1989). Twenty percent of the sample (n = 130) reported intrafamilial child sexual abuse. Extreme dieting behavior was found to be most significant among this subset of the sample, although bulimic and anorexic behaviors were positively associated with unwanted sexual experience in the sample as a whole.

Gregory-Bills and Vincent (1989) found that 87% (26 out of 30) of their subjects in a study of

psychopathology among incest survivors suffered from eating disorders. Their sample consisted of therapy outpatients being treated for ramifications of child incest experiences. Interestingly, survivors who had maintained secrecy about the incest were more likely to have eating disorders than those who had revealed the incest while being victimized.

Hall, Tice, Beresford, Wooley, and Hall (1989) investigated the relationship between anorexia and bulimia and a history of child sexual abuse in an inpatient sample of individuals being treated for eating disorders. In a sample of 158, 60 gave information to the treatment team regarding their own histories of child sexual abuse. Among anorexic and bulimic patients, 59% had suffered child sexual abuse, whereas only 28% of the patients with other diagnoses had child sexual abuse histories. The authors concluded from their study that a history of sexual abuse is very relevant information and that the treatment team needed this information to adequately help the patients.

Goldfarb (1987) and Schechter, Schwartz, and Greenfeld (1987) submitted case histories linking

both rape and child sexual abuse to the subsequent development of eating disordered behavior in clients. McClelland, Mynors-Wallis, Fahy, and Treasure (1991) confirm these observations as well as Hall et al´s (1989) proposal that sexual abuse history is relevant to eating disorders treatment. They examined the relationship between child sexual abuse, personality disorders, and eating disorders, identifying 30% of in-patients being treated for eating disorders as having suffered sexual abuse as children. They also note an association between eating disorder diagnosis, child sexual abuse, and personality disorder. While not asserting causality, the authors claimed that borderline/antisocial personality diagnoses seemed more frequent in patients with histories of severe sexual abuse and eating disorders.

While investigating borderline personality disorder and other symptoms of child sexual abuse survivors, Goodwin, Cheeves, and Connell (1990) noted that eating disorders were among the eleven most severe problems associated with severe child sexual abuse. In their study they evaluated 20 women who had been hospitalized for psychiatric problems. Fifteen of these women had current

eating disorder diagnoses. Goodwin et al (1990) characterized this finding as a way in which their subjects continued to inflict pain on themselves via self-destructive means.

In another study which examined correlates of borderline diagnoses with histories of child sexual abuse, Shearer, Peteres, Quaytman, and Ogden (1990) indicated that borderline patients with histories of sexual abuse "were significantly more likely to have a concomitant diagnosis of an eating disorder" (Shearer et al, 1990, p. 215).

Smolak, Levine and Sullins (1990) studied a non-clinical sample of college students to see if child sexual experiences predisposed women to eating disordered attitudes. Subjects in this study who had been sexually abused as children had higher total scores on the Eating Disorders Inventory(EDI),(Garner,1990), but noted that the differences disappeared on between-scales scores. Additionally, when they factored in abuse severity, EDI scores seemed to be unrelated. The authors concluded that no simple explanation or test revealed a straightforward relationship, due to the complexity of effects of child sexual abuse. So while a relationship does exist, as evidenced by

higher total scores, they implied that the relationship was not strong enough to suggest causality. They noted that the use of a non-clinical, high functioning sample may have skewed the results.

Finally, Finn, Hartman, Leon, and Lawson (1986) compared psychotherapy patients with and without histories of child sexual abuse, and found no significant difference between the two groups. They hypothesized that the lack of relationship is due to the high degree of prevalence of eating disordered behavior and attitudes among women in general. They proposed that therapists who note the relationship between child sexual abuse and eating disorders have not factored in social and cultural pressure that presses all women towards slenderness. Concomitantly, they postulated that the frequency of child sexual abuse among female psychotherapy clients might also confound clinical observation. That is, many female clients are likely to be eating disordered *and* have a history of sexual abuse, predisposing clinicians to note a relationship which falls away under the rigors of scientific examination.

# CHAPTER 3

# METHOD

## Subjects and Procedure

The subjects for this study were drawn from outpatient clients at the Women's Self-Help Center in Saint Louis. Subjects were in one-on-one psychotherapy addressing issues related to their experiences of sexual abuse as children. Subjects were given a packet with an introductory cover letter (see Appendix A) which explained the purposes of the study and guaranteed confidentiality if they agreed to participate. A consent form was also included (see Appendix B). Twenty five packets were distributed to therapists at the center which they offered to their clients with histories of child sexual abuse. No other screening of participants was performed by therapists. Therapists were instructed briefly on the nature of the study, and participation by both therapists and subjects was completely voluntary.

If a client was uncomfortable about participating and returned the packet to the therapist, the therapist would offer that packet to her other clients who fit the criteria. If a therapist had no more clients who fit the criteria,

she returned unused packets to the researcher who distributed those packets to other therapists with clients who fit the criteria. Of the twenty five packets distributed to subjects, eighteen were returned to the researcher completed.

All packets were returned to the researcher via normal postal service.

Materials

For the purpose of studying both eating disordered attitudes and distorted body image among women with histories of child sexual abuse, subjects completed two questionnaires. The first of these was designed by the researcher to determine the length of time during which they experienced sexual abuse, identity and number of abusers, if known, and whether or not the subject kept the abuse a secret (see Appendix C).

The second questionnaire employed was the Eating Disorder Inventory-2 (EDI-2) (Garner, 1990) (see Appendix D). The EDI-2 is a revision of the EDI-1 which originally contained 64 questions and eight subscales. The EDI-2 consists of 91 items which are divided into eight subscales and three provisional subscales. The original eight subscales measure Drive for Thinness, Bulimia, Body

Dissatisfaction, Ineffectiveness, Perfectionism, Interpersonal Distrust, Interoceptive Awareness, and Maturity Fears. The provisional subscales measure Asceticism, Impulse Regulation, and Social Insecurity. For the purposes of this study, only Drive for Thinness, Bulimia, and Body Dissatisfaction were examined (see Appendix E for a breakdown of subscale questions), and the EDI-1 would have been sufficient. However it is no longer available from the publisher and since the original subscales are unchanged, the EDI-2 was deemed suitable for these research purposes.

Reliability of the EDI-2 was determined by the test developers based on its administration to samples of anorexic and bulimic patients, female college students and female high school students. Overall internal consistency (Cronbach´s alpha) was above .80 for the anorexic-bulimic samples. and correlated with other similar measures at .63 (sd = .13). The test developer determined this to be a substantial correlation between instruments.

In terms of criterion validity, Garner (1990) compared results of the EDI-2 with independent clinical judgments of clinicians who were experienced with eating disorders. The

correlations between clinical judgments and EDI-2 subscales scores for the subscales used in this study were as follows: Drive for Thinness at .53, Bulimia at .57, and Body Dissatisfaction at .44. All three correlations were significant $p < .001$ (Garner,1990).

Examination of convergent and discriminant validity with other similar instruments was based on scores of anorexic/bulimic respondents. The three subscales utilized in this study showed an overall positive correlation with most other similar measurement instruments. The Drive for Thinness and Body Dissatisfaction scales showed stronger overall correlations with other tests; the Bulimia subscale on the EDI was most strongly correlated with the restraint subscale on the Eating Attitudes Test and the lack of self control subscale on the Locus of Control test (.48 and .57, respectively, at .0001).

All three subscales correlated with each of the other scales positively. The strongest relationship was between Drive for Thinness and Body Image Dissatisfaction ($r = .62$; significant at $p < .001$). The weakest relationship was between Bulimia and Body Image Dissatisfaction ($r = .33$; at

$p < .001$).

In addition to tests of validity and reliability, Garner (1990) cited several independent research projects (some of which are mentioned in the literature review of this study) which defend their assertions. The author specifically stated that the EDI-2 could be used for screening purposes, to gauge improvement of symptoms while individuals are in treatment, and to further research efforts, but do not suggest the EDI-2 as a diagnostic tool, due to the complexity of variables related to eating disorders.

Data Analysis

Descriptive statistics (i.e., range, mean, and standard deviation) were compiled. Descriptors regarding age and severity of abuse in terms of number of abusers and length of abuse were gathered to help further identify the sample makeup. To determine if there was a relationship between scales in this sample, Pearson's product moment correlation was performed between each pair of scales. Additionally, point-biserial correlations between each scale and the dichotomous variable of secretiveness were calculated.

# CHAPTER 4

## RESULTS

Among the eighteen respondents in this study, the mean age was 38.61 and the range fell between ages 29 and 58. The range of number of abusers was between one and four with a mean of 1.89. Six respondents revealed the fact of their abuse at the time that they were being abused, and twelve kept the abuse a secret. In each case where the abuse was revealed, the person in whom the abuse victim confided failed to protect the victim, either by denying the abuse or ignoring the victim.

In terms of the length of time subjects endured the abuse, Table 1 reveals that the overwhelming majority were abused for more than one year.

Table 1: Length of Time Respondents were Abused

| *Length of abuse* | *Number of respondents* |
|---|---|
| less than six months | 3 |
| six months to one year | 2 |
| one year to three years | 5 |
| more than three years | 8 |
| total | 18 |

Descriptive statistics regarding respondent scores on three scales of the EDI-2 are presented in Table 2.

Table 2: Means, ranges, and standard deviations of three scales on the EDI-2 among child sexual abuse survivors

| | *Mean* | *Range* | *S.D.* |
|---|---|---|---|
| EDI-2 Scale | | | |
| Drive for Thinness | 7.67 | 0–19 | 5.95 |
| Bulimia | 3.56 | 0–10 | 3.56 |
| Body Dis-satisfac-tion | 18.56 | 5–27 | 7.40 |

These results compare to the scores of anorexia nervosa (AN) bulimics, and a female comparison group (FCI) as reported by Garner (1990, p. 14) are presented in Table 3.

Table 3: Means and Standard Deviations of Anorexia Nervosa Bulimics (AN) and Female Comparison (FC) groups.

| | *AN Bulimic group* | | *FCI group* | |
|---|---|---|---|---|
| *EDI-2 Scale:* | *mean* | *S.D.* | *mean* | *S.D.* |
| DT | 15.0 | 5.6 | 5.5 | 5.5 |
| B | 8.9 | 5.8 | 1.2 | 1.9 |
| BD | 14.4 | 8.5 | 12.2 | 8.3 |

Pearson´s product moment correlations were computed to scale pairs the results are reported in Table 4.

Table 4: Correlations Between Subscale Pairs

| | DT | B | BD |
|---|---|---|---|
| Drive for Thinness | -- | .253 | .548** |
| Bulimia | .253 | -- | .431 |
| Body image Dissatis- faction | .548** | .431 | -- |

*n = 18, alpha .05, two tailed test.
**significant p between .02 and .01

Point-biserial correlation results indicated a significant relationship between whether or not the abuse was kept secret and the subjects´ scores on the Body Image Disturbance scale ($r = .48082$, $p$ between .05 and .02). No significant relationship was found between secretiveness and either the Bulimia or Drive for Thinness scale ($r$ = .2493 and .04076, respectively).

# CHAPTER 5

# DISCUSSION

As cited by Garner (1990) in his development of the EDI-2, body image disturbance can often be the hallmark of eating disordered thinking and behavior. This sample certainly evinces a greater than average degree of body image disturbance. In fact, the mean scores of this sample are greater than the means of both anorexic-bulemic patients and the female control group. This supports the notion that women who have been sexually abused as children have suffered enough invasions on their bodies as children to carry over into their adult lives. However, several factors may render this comparison, if not moot, at least questionable and in need of more detailed study.

First of all, respondents in this sample were considerably older than any other samples noted by the author of the EDI-2. Normative data was based on younger women who were either in treatment for eating disorders or college students. Since the average age of subjects in this sample was 38, this may also have had an impact on the relatively low scores on the Bulimia subscale, and

to a lesser extent the Drive for Thinness subscale. The relationships between subscales may also be confounded by differences in age. Nevertheless, a positive relationship between the Drive for Thinness and Body Image Disturbance subscales reveals enough underlying relatedness to enable the researcher to conclude that these women who have survived child sexual abuse display many of the characteristics of eating disordered thinking. Whether or not they act this out in terms of their answers to Bulimia subscale questions seems less clear. This data suggests that they do not.

The data may also be limited by the very nature of a self-report questionnaire. Perhaps women who are older, and in treatment for their problems, would not easily admit to behaviors which have been widely advertised as both "sick" and "typical college student behavior" as they might believe they ought to be past all of this nonsense. Indeed, one respondent wrote a short note to the researcher outlining her improvement in these areas since she has been in therapy. Alternatively another respondent noted separately that she believed that being overweight was the worst thing that could happen to someone. Body Image

Disturbance scores for both of these individuals was above the cutoff of 15 that Gardner (1990) suggests for screening purposes.

The data do reveal a large amount of body dissatisfaction among women in this sample who have all survived child sexual abuse. Further research might include study and comparison of eating disordered individuals who have been sexually abused as children with women who have also been sexually abused but do not have eating disorder as a major complaint. This might factor out some of the discrepant results in terms of correlation between subscales. A much larger sample would be neccessary to make this type of data meaningful.

In terms of the relationship between scale scores and whether or not the abuse was kept secret, the results of this study, while not conclusive, are worth noting. As overall results indicate, body image disturbance scores in this sample were very high. The only significant relationship between secretiveness and scale scores was between secretiveness and Body Image Dissatisfaction. This relationship may indicate that the intrusiveness of child sexual abuse could have some impact on the development of a healthy

body image, and that a child's ability to tell the truth about the abuse may be a reflection of that child's general ability to cope with those intrusions.

However, the relationship is not overwhelmingly strong,in fact, it is only barely significant. The variables which confound interscale correlations, such as age of the respondents and a general tendency for women in this culture to have disturbed body images, may also confound these results. This might account for the fact that secretiveness did not seem to be related to scores on the other two scales. In general, secretiveness was related to respondents' disturbed body image, but was unrelated to self reported eating disordered behaviors. So the results of this study do not indicate that whether or not a child sexual abuse survivor told someone about the abuse is related to subsequent development of an eating disorder. But secretiveness does seem to be related in some way to subjects' own reports of body image disturbance. And if Garner's (1990) notion that body image disturbance is a crucial component of eating disorders has merit, this finding bears futher investigation.

Another relevant idea for further research would be to investigate a relationship, if any, between eating disorders and length of sexual abuse. The sample size of this study was not large enough to test the independence of these two variables from scores on the EDI-2, yet the descriptive results indicate that the majority of respondents had been sexually abused for more than one year. In a future study with a larger sample this variable might prove to be more indicative of the nature of the effect of the abuse on body attitudes and eating disorders.

In conclusion, this study examined the relationship between body image dissatisfaction and eating disordered behavior and attitudes in women who survived child sexual abuse. The hypothesis that women in this sample would score high on three scales which measure body dissatisfaction, and eating disordered attitudes and behaviors was born out most reliably on the body image scale scores. The proposal that a higher score on a body dissatisfaction scale would be closely related to eating disordered attitudes and behaviors was coaxed from the data. But this result was mixed, in that the relationship between body image

disturbance and eating disordered behavior scales depended on which scale was examined.

The hypothesis that secretiveness surrounding the abuse would be related to scores on subscales was not suppported by the data. The results do not demand a radical change in either treatment or philosophy concerning this population, as many of the previous assumptions about child sexual abuse survivors are upheld or at least not challenged. Hopefully, the full significance of body image disturbance among both sexual abuse survivors and those afflicted with eating disorders will continue to be investigated, with an eye towards teasing out the relationship between these variables.

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# APPENDICES

# APPPENDIX A

August 14, 1991

Dear Potential Participant,

As a part of the completion of my master's degree in psychology I am conducting a study which might interest you. The purpose of the study is to see if there is some relationship between eating behaviors and body image among women who have survived child sexual abuse. In the past, many studies have been performed on the relationship between eating behavior and how women perceive their own bodies, but very little is known about the special concerns that incest survivors may have about these two problems. I would like to ask for your help in the investigation of this idea.

The kind of help I need would take between 20 and 40 minutes of your free time at home. If you consent to participate in my study, the attached packet contains two short questionnaires, which you would fill out and put in the mailbox whenever you have completed them. You will not be asked to identify yourself; each part of the packet will have a number assigned to it to make sure that both questionnaires have been filled out by the

same person.

As a participant in this study you have the right to full protection of your privacy. The results of your questionnaires will be strictly confidential. The results of the study as a whole will be part of my master's thesis, and will be bound and placed on the shelves at the library at Lindenwood College as well as in the library of the Women's Self Help Center. No individual participants will be identified in the study, although the overall results of the research will be available to those who are interested.

If you have further questions about confidentiality, or the nature of the research, you may contact me at the phone number below. You may contact me before you decide to participate in order to help you make your decision. I will supply as much information as I can. You may also contact me following your participation if you have any remaining questions about the purpose of the study, or other concerns about having participated.

If you decide to participate in this study, please sign the consent form in the envelope and return it with your completed questionnaires. When you sign this form it gives me permission to use

the data from your questionnaires. It also contains a statement pertaining to my responibility to protect your privacy.

I would like to thank you in advance for the important contribution you will be making to a better and clearer understanding of issues which concern survivors of child sexual abuse.

Sincerely,

Ellen Dorfman
Graduate Intern
Women's Self Help Center
531-9100

# APPENDIX B

I give my permission for Ellen Dorfman to use the data she collects from my answers to two questionnaires for the purposes of her research. I understand that I will not be identified individually in her study and that she has the responsibility to protect my privacy. Furthermore, I understand that she will answer any and all questions I may have about her research to the best of her ability, and that the results will be available both to me and the general public in the form of an unpublished thesis.

Signed,

______________________________

(signature)

______________________________

(today´s date)

# APPENDIX C

This questionnaire´s purpose is to help the researcher understand some of the things that happened to you when you were younger. Please answer each question as well as you can. If you can´t answer a question skip it and go on to the next one. Please circle the number of the answer(s) that apply and fill in the blanks when appropriate. It is fine to have more than one answer to any question. Thank you very much for your help.

Were you touched sexually by someone older than you at any time during your childhood? (through age 18)

1.yes 2.no 3. don´t remember

Who touched you?

1. Father or step-father
2. Brother
3. Sister
4. Uncle
5. Mother´s partner
6. Other relative
7. Neighbor/Babysitter/Family friend
8. Other
9. Don´t remember

How long were you sexually abused?

1. less than six months

2. six months to one year

3. one to three years

4. more than three years

Did you tell anyone that you were being sexually abused at the time of the abuse?

1. yes 2. no

If so, who did you tell?______________________________

______________________________________________________

______________________________________________________

Did the person you told... (circle those that apply)

1. protect you/remove your from the situation

2. deny that you were abused

3. ignore you

4. get you into treatment

# APPENDIX D

The following is a copy of the Eating Disorders Inventory-2 (Garner, 1990).

1. I eat sweets and carbohydrates without feeling nervous.
2. I think that my stomach is too big.
3. I wish that I could return to the security of childhood.
4. I eat when I am upset.
5. I stuff myself with food.
6. I wish that I could be younger.
7. I think about dieting.
8. I get frightened when my feelings are too strong.
9. I think that my thighs are too large.
10. I feel ineffective as a person.
11. I feel extremely guilty after overeating.
12. I think that my stomach is just the right size.
13. Only outstanding performance is good enough in my family.
14. The happiest time in life is when you are a child.
15. I am open about my feelings.
16. I am terrified of gaining weight.
17. I trust others.
18. I feel alone in the world.
19. I feel satisfied with the shape of my body.
20. I feel generally in control of things in my life.
21. I get confused about what emotion I am feeling.
22. I would rather be an adult than a child.
23. I can communicate with others easily.
24. I wish I were someone else.
25. I exaggerate or magnify the importance of weight.
26. I can clearly identify what emotion I am feeling.
27. I feel inadequate.
28. I have gone on eating binges where I felt that I could not stop.
29. As a child, I tried very hard to avoid disappointing my parents and teachers.
30. I have close relationships.
31. I like the shape of my buttocks.
32. I am preoccupied with the desire to be thinner.
33. I don't know what's going on inside me.
34. I have trouble expressing my emotions to others.
35. The demands of adulthood are too great.
36. I hate being less than best at things.
37. I feel secure about myself.

38. I think about bingeing (overeating).
39. I feel happy that I am not a child anymore.
40. I get confused as to whether or not I am hungry.
41. I have a low opinion of myself.
42. I feel that I can achieve my standards.
43. My parents have expected excellence of me.
44. I worry that my feelings will get out of control.
45. I think my hips are too big.
46. I eat moderately in front of others and stuff myself when they're gone.
47. I feel bloated after eating a normal meal.
48. I feel that people are happiest when they are children.
49. If I gain a pound, I worry that I will keep gaining.
50. I feel that I am a worthwhile person.
51. When I am upset, I don't know if I am sad, frightened, or angry.
52. I feel that I must do things perfectly or not do them at all.
53. I have the thought of trying to vomit in order to lose weight.
54. I need to keep people at a certain distance (feel uncomfortable if someone tries to get too close).
55. I think that my thighs are just the right size.
56. I feel empty inside (emotionally).
57. I can talk about personal thoughts or feelings.
58. The best years of your life are when you become an adult.
59. I think my buttocks are too large.
60. I have feelings I can't quite identify.
61. I eat or drink in secrecy.
62. I think that my hips are just the right size.
63. I have extremely high goals.
64. When I am upset, I worry that I will start eating.
65. People I really like end up disappointing me.
66. I am ashamed of my human weaknesses.
67. Other people would say that I am emotionally unstable.
68. I would like to be in total control of my bodily urges.
69. I feel relaxed in most group situations.
70. I say things impulsively that I regret having said.
71. I go out of my way to experience pleasure.
72. I have to be careful of my tendency to abuse drugs.
73. I am outgoing with most people.
74. I feel trapped in relationships.
75. Self-denial makes me feel stronger spiritually.
76. People understand my real problems.

# APPENDIX E

The following is a breakdown of subscale questions for the three EDI-2 scales (Garner, 1990) utilized in this study.

LINDENWOOD COLLEGE LIBRARY

*Drive for Thinness*

1. I eat sweets and carbohydrates without feeling nervous.
7. I think about dieting.
11. I feel extremely guilty after overeating.
16. I am terrified of gaining weight.
25. I exaggerate or magnify the importance of weight.
32. I am preoccupied with the desire to be thinnner.
49. If I gain a pound, I worry that I will keep gaining.

*Bulimia*

4. I eat when I am upset.
5. I stuff myself with food.
28. I have gone on eating binges where I felt that I could not stop.
38. I think about bingeing (overeating).
46. I eat moderately in front of others and stuff myself when they're gone.

53. I have the thought of trying to vomit in order to lose weight.

61. I eat or drink in secrecy.

*Body Dissatisfaction*

2. I think that my stomach is too big.

9. I think that my thighs are too large.

12. I think that my stomach is just the right size.

19. I feel satisfied with the shape of my body.

31. I like the shape of my buttocks.

45. I think my hips are too big.

55. I think that my thighs are just the right size.

59. I think my buttocks are too large.

62. I think that my hips are just the right size.