

**REPORTED**  
**SEXUAL ABUSE AND**  
**BULIMIC SYMPTOMS:**  
**THE MEDIATING ROLE**  
**OF DISSOCIATION**

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## **ABSTRACT**

*There is only inconclusive evidence of a specific association between a history of sexual abuse and diagnosable eating disorders. However, there is stronger support for a link between sexual abuse and bulimic symptomatology. The mediating factors in this relationship are still unclear. Dissociation appears to be a strong candidate, given its links to both early trauma and bulimic psychopathology. This study examines the role of dissociation as a potential mediating factor in the relationship between a reported history of sexual abuse and specific bulimic behaviors in 60 women with eating disorders. A reported history of sexual abuse was associated with greater dissociation and with a greater frequency of bingeing. In an Analysis of Covariance, dissociation accounted for the association between a reported history of sexual abuse and frequency of bingeing. Further research is required to determine the other factors involved in this relationship.*

Studies have linked a reported history of abuse with a number of psychiatric disorders (Briere & Zaidi, 1989; Hall, Tice, Beresford, Wooley, & Hall, 1989; Mullen, Romans-Clarkson, Walton, & Herbison, 1988). In particular, there has been considerable interest in the association between a history of sexual abuse and the eating disorders (Bulik, Sullivan, & Rorty, 1989; Lacey, 1990; Oppenheimer, Howells, Palmer, & Chaloner, 1985; Palmer & Oppenheimer, 1992; Welch & Fairburn, 1994). The findings of these studies are mixed, with a range of prevalence rates reported, suggesting that

any link between abuse and the eating disorders may not be a specific one (Pope & Hudson, 1992; Conners & Morse, 1993).

There appears to be particular utility in considering a specific link to bulimic symptomatology (Bushnell, Wells & Oakley-Browne, 1992; Hastings & Kern, 1994; Pribor & Dinnwiddie, 1992; Root & Fallon, 1988; Steiger & Zanko, 1990; Waller, 1991, 1992). The research suggests that a reported history of sexual abuse is not linked directly to a diagnosis of bulimia nervosa. Rather, there appears to be a specific link to the bulimic behaviors of bingeing and purging (Pitts & Waller, 1993; Waller, 1992). Functional models suggest that bingeing and purging behavior can serve a number of defensive purposes (Lacey, 1986), and that those defenses are especially valuable for the bulimic with a history of abuse (Root & Fallon, 1989). In particular, it is proposed that a temporary cognitive narrowing is experienced during a binge as the bulimic refocuses attention on to the immediate stimulus. This refocusing allows a reduction in negative affect or a general reduction in self-awareness (Heatherton & Baumeister, 1991). In the case of a woman who has a history of sexual abuse, there are likely to be a number of intolerable emotional states present, due to the unresolved nature of the experience (Briere, 1992). Consequently, there will be a greater need for this reduction in awareness in women with such a history.

This pattern of "escaping from awareness" appears to involve cognitive processes similar to those that underpin the concept of dissociation. Dissociation is a relatively primitive defense mechanism, which is characterized by poor integration of thought processes (Spiegel, 1986). It can involve feelings of absorption, derealization/depersonalization, and amnestic dissociation (memory loss). Although dissociation is a natural cognitive process, especially in response to trauma (e.g., Spiegel & Cardena, 1991), with continued use over time it can become maladaptive. High levels of dissociation have been found in a number of psychiatric disorders, including multiple personality disorder, borderline personality disorder, post-traumatic stress disorder, and the eating disorders (e.g., Carlson & Putnam, 1993). A number of studies have reported dissociative tendencies in eating-disordered women (Abraham & Beumont, 1982; Demitrack, Putnam, Brewerton, Brandt, & Gold, 1990; Goldner, Cockhill, & Bakan,

1990). There appears to be a particular association with bulimic symptomatology (Everitt, Waller, & Macdonald, 1995; Sanders, 1986). Bulimics' descriptions of their experiences also indicate that dissociative experiences are common in this group (Charandana & Malla, 1989; Johnson, Tobin, & Dennis, 1990; Torem, 1986; Vanderlinden & Vandereycken, 1990).

Among the traumatic experiences that are reported by individuals with high levels of dissociation, a reported history of sexual abuse is common (Briere & Run tz, 1988; Sanders & Giolas, 1991; Sanders, McRoberts, & Tollefson, 1989). On the basis of the existing literature and clinical experience, a number of authors have advanced the hypothesis that there might be a three-way relationship between a reported history of sexual abuse, bulimic eating disorders, and dissociation (e.g., Miller, McCluskey-Fawcett & Irving, 1991; Vanderlinden, Vandereycken, van Dyck & Vertommen, 1993). Briere (1992) and McCarthy, Goff, Baer, Cioffi, and Herzog (1994) suggest that dissociation may act as a critical mediator in the relationship between childhood abuse (either physical or sexual) and bulimia. However, there is little direct evidence for this proposed model.

It is the aim of this study to test the proposed model that links sexual abuse, dissociation, and bulimic symptomatology. It is hypothesized that bulimic symptomatology will be greater where a history of abuse is reported (as shown by Waller, 1992), and that dissociation will act as a mediating factor in this relationship. The "escape from awareness" model (Heatherton & Baumeister, 1991) suggests that this relationship will be particularly strong in the case of bingeing behavior. In other words, eating-disordered women who report a history of sexual abuse will have a greater frequency of bulimic behaviors, and that increase (particularly in bingeing) will be accounted for by their higher level of dissociation.

## METHOD

### Participants

Sixty eating-disordered women participated in the study. They were recruited from consecutive attenders at a local eating disorder service for university students (42 women) and at a National Health Service clinic (10 women), and from a self-help group (eight women). This is a different group of women to those reported by Waller (1991, 1992, 1993). The mean age of the women in this sample was 22.8 years ( $sd = 6.27$  years), and their mean Body Mass Index (BMI-Llewellyn-Jones & Abraham, 1984) was 21.7 ( $sd = 4.01$ ). They were all diagnosed as having an anorexic or a bulimic eating disorder according to DSM-IV criteria (American Psychiatric Association, 1994). There were five restrictive anorexics, ten anorexics of the bulimic subtype, 30 bulimics with no history of anorexia, and 15 bulimics with a history of anorexia.

### Measures and Procedures

During assessment, the women completed two questionnaire measures. The Eating Attitudes Test (EAT-26-Garner, Olmsted, Bohr, & Garfinkel, 1982) measures eating attitudes and behaviors, and includes three subscales (dieting, bulimia, and oral control). The Dissociative Experiences Scale (DES-TI-Carlson & Putnam, 1993) is a measure of the extent of dissociative tendencies, and has three subscales (absorption and imaginative involvement, depersonalization/derealization, amnestic dissociation). The women were also interviewed during the initial assessment sessions regarding a history of unwanted sexual experiences, using the interview and the criteria for sexual abuse that are outlined in an earlier paper (Waller, 1991). This definition of sexual abuse is relatively broad. It includes contact and non-contact experiences, at any age (prior to the development of the eating disorder), and involving any perpetrator. Information regarding frequency of bingeing and vomiting was collected via eating diaries, which the women kept for two weeks after the initial assessment (as described by Waller, 1992). Diaries appear to be preferable to immediate self-report, as research suggests that some multi-impulsive bulimics have a tendency to overestimate bingeing and purging severity if immediate self-report is used (Fahy & Eisler, 1993).

### Data Analysis

Initially, Analyses of Variance (AN OVA) were used to compare the frequency of bulimic behaviors (bingeing and vomiting), Eating Attitudes Test scores (EAT-26), and levels of dissociation (DES-II) of the women reporting a history of sexual abuse and those reporting no such history. In order to determine the role of dissociation as a mediator between sexual abuse and eating symptoms, Analysis of Covariance (ANCOVA) was used. The women's ages and their levels of dissociation were partialled out when comparing the severity of eating psychopathology of those women who did and who did not report a history of sexual abuse.

## RESULTS

### Presence and Nature of Reported Sexual Abuse

Of the 60 women who participated in the study, 29 (48.3%) reported any sexual abuse. This is a similar rate to that found in previous studies on this population when using the same definition of and assessment for such abuse (Waller, 1991, 1992). There was no significant association [ $X^2 = 5.14$ ;  $df = 3$ ; ns] of reported sexual abuse and diagnostic category (abuse was reported by four of the five restrictive anorexics, seven of the ten anorexics with bulimic symptoms, 12 of the 30 bulimics with no history of anorexia, and six of the 15 bulimics with a history of anorexia). For the 29 women who reported abuse, the mean age at first abuse was 11.9 years ( $sd = 5.61$ ; range 2-22). The mean duration of reported abuse was 4.48 years ( $sd = 7.74$ ; range 0-37). Eight women (27% of the

total number reporting abuse) reported abuse involving a family member. Finally, nine women (32%) reported abuse involving force.

#### *Relationship Between Reported Sexual Abuse and Eating/Dissociative Characteristics*

Compared to the patient series described by Waller (1992), the women in this sample reported lower frequencies of bingeing per week among the abused group (4.93 in the present sample vs. 10.3 in the earlier sample) and the non-abused group (2.60 vs. 6.69). Frequency of vomiting was also lower in this patient sample for the abused group (4.90 vs. 9.54) and the non-abused group (4.47 vs. 7.91). Table 1 shows the mean age, BMI, EAT-26, DES-II, and frequencies of bingeing and vomiting per week, for the women who reported sexual abuse and for those who reported no abuse. Two-tailed ANOVAs were used to compare the scores on these measures. There were no significant differences between the groups in BMI, EAT-26 scores, or frequency of vomiting (as found by Waller, 1992). However, the abused group were older than the non-abused women, had significantly greater DES-II scores, and reported a greater frequency of binges per week.

#### *Mediating Role of Dissociation*

Greater dissociation was associated with a greater frequency of bingeing ( $r = .51$ ;  $p < .0001$ ). However, there was no significant correlation between DES-II scores and frequency of vomiting per week ( $r = -.04$ ). Analysis of Covariance was used to determine the relationship between sexual abuse and bingeing behavior, when the significant differences in the groups' ages and DES-II scores were accounted for. There was no significant covarying effect of the difference in the groups' ages [ $F(1,56) = 0.84$ ;  $p = .36$ ]. However, when the significant effect of the DES-II scores [ $F(1,56) = 18.7$ ;  $p < .0001$ ] was partialled out, there was no reliable difference in frequency of bingeing between those women who did and did not report abuse [ $F(1,56) = 1.05$ ;  $p = .31$ ]. This finding suggests that dissociation acts as a mediating factor in the relationship between sexual abuse and bingeing.

TABLE 1  
Comparisons of the Characteristics of the Women Reporting Sexual Abuse and Those who Report no Such History

	<b>Group</b>		<b>ANOVA</b>	
	<b>No Reported Abuse</b>	<b>Reported Abuse</b>	<b>F</b>	<b>p</b>
N	31	29		
Age	20.7	25.0	7.96	.01
(sd)	(2.70)	(8.09)		
Body Mass Index	21.9	21.5	0.22	.ns
(sd)	(3.18)	(4.79)		
EAT-26	35.7	36.9	0.12	.ns
(sd)	(10.7)	(15.0)		
Binges per week	2.60	4.93	6.01	.02
(sd)	(2.13)	(4.83)		
Vomiting per week	4.47	4.90	0.12	.ns
(sd)	(5.24)	(4.14)		
DES- II	14.2	23.2	7.46	.01
(sd)	(10.5)	(14.6)		

## DISCUSSION

This study investigated the mediating role of dissociation in the relationship between a reported history of sexual abuse and bulimic symptomatology. Unlike the finding of Waller (1991), there was no significant association between the prevalence of reported sexual abuse and diagnostic category. In addition, the severity of bulimic behaviors in this sample is lower than that reported by Waller (1992). These differences may reflect the nature of the sample used in this study (a greater proportion of university students rather than health service referrals, and the inclusion of restrictive anorexics). However, despite this difference in samples, a reported history of sexual abuse was associated with a greater frequency of bingeing, as shown by Waller (1992). The women who reported abuse also had greater levels of dissociation, as reported by Miller et al. (1991) and Vanderlinden et al. (1993). Furthermore, dissociation was shown to be a mediating factor in the relationship between sexual abuse and frequency of bingeing. However, neither dissociation or sexual abuse was able to account for the severity of vomiting.

The results of this study are compatible with a model of

abuse-related tension-reducing behaviors proposed by Briere (1992). This model suggests that a stressful event (e.g., anticipated or perceived betrayal or conflict) causes a resurfacing of powerful feelings connected to unresolved childhood abuse issues. The ensuing intolerable cognitive state triggers the use of dissociation and a search for a tension-reducing behavior, such as bingeing. This behavior is suggested to serve a number of specific functions, including temporary distraction, a filling of emptiness, and numbing of psychic pain. While temporary relief is experienced, it is proposed that the person also has subsequent feelings of guilt or disgust at the behavior. There follows a renewed resolve to resist such behavior in the future. However, the behavior is likely to be relied upon again, due to its pain and tension-reducing effects.

While this model suggests an explanation for the association between reported sexual abuse, dissociation and bingeing, it is important to note that these variables were unable to predict the frequency of vomiting. This disparity suggests that bingeing and vomiting may serve to block out different cognitions or emotions. Pitts & Waller (1993) report that the severity of vomiting is associated with specific self-denigratory cognitions relating to a reported history of sexual abuse. In combination with the present results, this finding suggests that bingeing may tend to serve the function of reducing intolerable general emotional states in women with a history of abuse, while vomiting maybe more likely to serve the function of reducing awareness of specific intolerable cognitions in the same group.

Further research is necessary to formulate a model of bulimic symptomatology that incorporates a history of sexual abuse as a significant potential risk factor. It is likely that a number of other mediating factors will be involved in this relationship (e.g., borderline personality disorder - Waller, 1993) and the specific functions that the bulimic behaviors might serve for an abused person would need to be considered. Further understanding of the relationship between tension-reducing behaviors and a history of sexual abuse has the potential to explain a number of other addictive, self-destructive behaviors.

This study has a number of important clinical implications. Again, the importance of enquiring about a history of abuse in eating-disordered women is emphasized. Clinicians need to be aware that the bingeing and vomiting behaviors of a bulimic with a reported history of sexual abuse may serve distinct functions (e.g., Root & Fallon, 1989). Therefore, it is necessary to ensure that any abuse-related cognitions or emotions that may be associated with the bulimic behaviors are addressed therapeutically. Addressing these abuse-related cognitions may prevent the bulimic behaviors being replaced, during treatment, by other tension-reducing behaviors (Coker, Vize, Wade, & Cooper, 1993; Yager, Landsverk, Edelstein, & Jarvik, 1988) or by increased dissociative tendencies (Schwartz & Gay, 1993). ■

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