# Psychopathology in Sexually Abused and Non-Sexually Abused Eating Disordered Women

J. Kelly Moreno
Michael J. Selby
Sherre Neal

**ABSTRACT.** The Prevalence of psychopathology was examined in sexually abused (SA) (n = 50) and non-sexually abused (NSA) (n = 83) eating disordered women. All women were administered a battery of personality and familial interaction measures including the Beck Depression Inventory (BDI), Beck Anxiety Inventory (BAI), State-Trait Anger Expression Inventory (STAXI), Millon Clinical Multiaxial Inventory (MCMI), Coopersmith Self-Esteem Inventory (CSEI) and the Family Adaptability and Cohesion Scale (FACES). Results showed the MCMI Schizotypal scale to be the best predictor of SA group membership. Other variables significantly associated with the SA group were (1) MCMI Avoidant scale, (2) MCMI Schizoid scale, (3) MCMI Passive-Aggressive scale, (4) MCMI Borderline scale, (5) CSEI, and (6) the Cohesion scale from the FACES. Implications for diagnosis and treatment, and directions for future research are discussed. *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-342-9678. E-mail address: getinfo@haworthpressinc.com]*

The manifestation of various forms of psychopathology arising from child sexual abuse is well documented (e.g., Conte, 1988; Finkelhor & Browne, 1988, Root, 1991). These forms range from severe

J. Kelly Moreno, PhD, and Michael J. Selby, PhD, are affiliated with California Polytechnic State University, San Luis Obispo, CA.

Sherre Neal, MS, is affiliated with the University of California, Santa Barbara, CA.

Address correspondence to J. Kelly Moreno, PhD, Department of Psychology, California Polytechnic State University, San Luis Obispo, CA 93407.

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psychiatric disorders (e.g., depression, multiple personality disorder, post-traumatic stress disorder) to a number of symptoms associated with a wide variety of syndromes, including low self-esteem, anger, social phobia and poor interpersonal relationships. In addition, a history of child sexual abuse appears to exacerbate a pre-existing mental disorder. For example, psychiatric patients with a history of child sexual abuse have been found to display more complex symptomatology compared to psychiatric patients without such a history (Briere, 1989; Courtois, 1988).

Dysfunctional familial interaction patterns have also been implicated in child sexual abuse by providing the environmental context (e.g., enmeshment of family members, inflexibility, patriarchal structure) within which the abuse occurs. For example, Hulsey, Sexton and Nash (1992) studied family interaction patterns in women with a history of sexual abuse and found abused subjects reported a higher incidence of familial isolation and authoritarianism, and a lower level of autonomy compared to the families of women with no history of sexual abuse. On the other hand, familial support following sexual abuse can significantly reduce the psychopathological impact of the experience on the child (Sgroi & Dana, 1982; Ryan, 1986).

## EATING DISORDERS

Past research has shown that eating disordered women, compared to non-eating disordered women, exhibit a number of psychopathological symptoms, including obsessive-compulsive behavior, depression, anxiety, anger, paranoid ideation, substance abuse, self-mutilation, impulsivity and low self esteem (Anderson, 1984; Brownell & Foreyt, 1986; Weiss & Ebert, 1983). Studies of familial interaction patterns among eating disordered subtypes have reported mixed findings. However, families of restricting anorectics, when compared to families of bulimic women, have generally been described as exhibiting greater enmeshment, overprotectiveness and rigidity (Johnson & Connors, 1987; Wonderlich, 1992), while families of bulimics have been reported to exhibit greater levels of underinvolvement, disengagement, disorganization, hostility and neglect (Johnson & Connors, 1987; Wooley & Wooley, 1985).

*Child Sexual Abuse.* A recent review of the literature indicates that 30-50% of women with eating disorders report a history of child sexual abuse (Connors & Morse, 1993; Neal & Moreno, 1993). Studies have also indicated a causal link between eating disordered women with a history of child sexual abuse and the manifestation of specific forms of psychopathology (e.g., Palmer et al., 1990; Waller, 1991). For example, Schwartz and Gay (1994) reported a subset of eating disordered women with a history of sexual abuse who exhibited a significantly greater number of symptoms associated with post-traumatic stress and dissociative disorder. However, it has also been noted that the issue of comorbidity is obscured by methodological confounds and the heterogeneity of eating disordered populations (Connors and Morse 1992).



## SUMMARY

In summary, previous research has shown sexually abused individuals to exhibit greater psychopathology and familial dysfunction than non-sexually abused subjects. Further, eating disordered women tend to exhibit higher levels of psychopathology compared to non-eating disordered samples. However, few studies have examined the relationship between psychopathology and eating disordered women with a history of child sexual abuse. The purpose of the present study was to examine the interrelationship between these factors and discuss their implications for assessment, diagnosis and treatment.

## METHOD

### Subjects

Subjects were 133 women with a DSM-III-R (American Psychiatric Association, 1987) diagnosis of eating disorder (anorexia, bulimia, eating disorder NOS) who had been admitted to Cottage Hospital, a private, non-profit treatment facility located in Santa Barbara, California. Of this group, 50 women reported one or more incidences of child sexual abuse (SA), with 83 women reporting no history of abuse (NSA). The mean age of the total sample was 28.9. The mean ages of the abused and non-abused groups were 31.2 and 27.5, respectively. A t-test comparison between groups showed no significant difference

with respect to age. No information was gathered regarding the age of the subject at the time of the abuse. Eighty-eight percent of the sample were Caucasian, eight percent were Hispanic, two percent were African-American, and two percent were of Asian extraction. The socio-economic status of the sample was middle to upper class. Nearly all subjects had insurance that allowed for inpatient treatment, but several beds on the unit were reserved for Medi-Cal/Care patients received from Santa Barbara County Mental Health.

### *Assessment of Sexual Abuse*

Hospital records were used to obtain sexual abuse history. Sources of information included psychosocial history, psychiatric evaluation, medical evaluation, nursing evaluation, discharge summary, and progress notes contained in each patient's chart. Subjects were placed into the sex abuse category if one or more of the following activities took place: Invitation to do something sexual; kissing/hugging in a sexual way; showing organs to others (or vice versa); fondling or being fondled; penetration without intercourse; intercourse. Also, the subject had to be 12 or less years of age and the perpetrator 17 or more years of age, or the subject was between the ages of 13 and 16 and the perpetrator was five years or more older than the subject.

Seven percent of the sexually abused sample had been abused for less than a month, three percent had been abused for less than a year, and 15% for longer than a year. The remainder of the sample were unclear as to the duration of the sexual abuse. With regard to abuse frequency, seven percent of the sample reported a single incidence of abuse, 6 percent several incidences, and seven percent multiple incidences. The remaining subjects were either unclear (19%) or data was unavailable.

Patients admitted to the eating disorder program were routinely assessed within 72 hours by a physician, psychiatrist, counselor, psychologist, and nurse, whose written clinical impressions were placed in their medical record. Each patient was administered an extensive battery of psychological tests, and therapeutic progress notes were regularly placed in their medical charts. Following discharge from the program, a masters level research assistant in Clinical Psychology reviewed each patient's chart and coded for sexual abuse.



### *Instruments*

The following measures were selected for their well-established psychometric properties and their relevance to the assessment of personality integration: (1) The State-Trait Anger Expression Inventory (STAXI: Spielberger, 1983); (2) The Beck Depression Inventory (BDI: Beck, Rush, Shaw & Emery, 1979); (3) The Beck Anxiety Inventory (BAI: Beck, Epstein, Brown & Steer, 1988); (4) The Eating disorders Inventory (EDI: Garner, Olmstead & Polivy, 1983); (5) The Coopersmith Self-Esteem Inventory (CSEI: Coopersmith, 1981); (6) The Millon Clinical Multiaxial Inventory (MCMI-II: Millon, 1987); and (7) The Family Adaptability and Cohesion Scales (FACES: Olsen et al., 1982).

## *RESULTS*

Bivariate correlations were calculated to determine which research variables had the strongest relationship to eating disordered women with sexual abuse history (Table 1). Variables with significant correlations were: (1) MCMI Schizoid scale ($r = .228, p < .05$), (2) MCMI Avoidant Scale ($r = .295, p < .01$), (3) MCMI Passive-Aggressive scale ($r = .247, p < .05$), (4) MCMI Schizotypal scale ($r = .299, p < .01$), (5) MCMI Borderline scale ($r = .262, p < .05$), (6) CSEI ($r = -.387, p < .01$), and (7) FACES Cohesion scale ($r = -.246$). A step-wise multiple regression was then performed to determine which of these variables significantly discriminated between SA and NSA groups. Results showed only the MCMI Schizotypal scale to be a significant predictor of SA group membership (Multiple $R = .434, p = .003$). Thus, while all predictor variables were significantly associated with SA group membership, none added to the explained variance between the SA and NSA groups over and above the variance accounted for by the MCMI Schizotypal scale alone.

## *DISCUSSION*

Present findings are consistent with previous research showing that eating disordered women with a history of child abuse exhibit significantly greater degrees of psychopathology compared to eating disor-

TABLE 1. Correlations between Clinical Variables and History of Child Sexual Abuse

| MCMI | r | BECK | r |
|---|---|---|---|
| Schizotypal | .289* | Depression | .165 |
| Avoidant | .295** | Anxiety | .206 |
| Dependent | .105 | | |
| Histrionic | −.154 | STAXI | |
| Narcissistic | −.158 | | |
| Antisocial | −.061 | State | .058 |
| Aggressive | −.042 | Trait | −.040 |
| Compulsive | −.047 | Anger In | .161 |
| Pass-Aggress. | .247* | Anger Out | .224 |
| Self Defeating | .191 | | |
| Schizotypal | .299** | COOPERSMITH | −.387** |
| Borderline | .262* | | |
| Paranoia | −.147 | FACES | |
| Anxiety | .031 | | |
| Somatization | −.211 | Cohesion | −.246* |
| Bipolar | −.090 | Adaptation | −.186 |
| Dysthymia | .109 | | |
| Alcohol Abuse | .191 | EDI | |
| Drug Abuse | .054 | Drive for Thinness | −.147 |
| Depression | .165 | Bulimia | .039 |
| | | Body Distortion | .041 |
| | | Perfectionism | −.032 |

* $p < .05$
** $p < .01$

dered women with no history of child abuse. With regard to specific psychopathological differences, the SA group was found to report a significantly greater number of symptoms associated with Borderline personality disorder (BPD) compared to the NSA group. This finding supports previous research which has shown a strong association between BPD and a history of child abuse (American Psychiatric Association, 1987). However, previous research has not reported a significant relationship between child abuse and the presence of schizotypal, schizoid, passive aggressive or avoidant symptoms. These findings may be related to the fact that the sexually abused child has greater difficulty in developing trust in interpersonal relationships, resulting in the adoption of a number of maladaptive, even peculiar, coping



behaviors which are associated with these personality disorders. For example, the presence of passive aggressive symptoms may indicate a maladaptive attempt to cope with repressed rage that is often found in victims of child sexual abuse (Donaldson & Gardner, 1985; Briere & Runtz, 1988).

The SA group was also found to report significantly lower levels of self esteem than the NSA group. While low levels of self esteem have commonly been found among women with a history of eating disorder or child sexual abuse, present findings suggest that a combined history of eating disorder and child abuse has a significantly greater negative impact on self concept than either one alone. This is understandable, given that feelings of powerlessness, loss of control, helplessness and emotional trauma experienced by a victim of sexual abuse would be compounded for persons suffering from an eating disorder.

On the other hand, potential bias in measurement and procedure in this study limits its usefulness. Additional research might use more instruments with validity scales and/or two or more raters who have demonstrated a high degree of interrater reliability when coding from medical records. Likewise, this study included observations on eating disordered women, as determined by the DSM-III-R. In the future, it would be useful to see how psychopathology varies across abused vs. nonabused eating disordered subtypes, as determined by the DSM IV.

## *DIAGNOSTIC AND TREATMENT IMPLICATIONS*

Our study suggests that the presence of symptoms associated with Schizotypal personality disorder in eating disordered women may be a useful diagnostic sign of a history of child sexual abuse. Other clinically relevant symptoms include low self esteem, low family cohesion, and symptoms associated with avoidant, schizoid, and borderline personality disorder. With respect to treatment, sexually abused eating disordered persons may not respond as well to short-term psychoeducational and cognitive-behavioral strategies for symptom control. Underlying difficulties with basic trust, boundaries, affect modulation, reality testing, and self expression may require additional time and additional methods (e.g., group therapy) to change longstanding problems relating to self and others, as well as to food.

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