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DISORDERED EATING AND PERCEPTIONS OF CHILDHOOD ABUSE AMONG WOMEN IN A PRIMARY CARE SETTING

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Research has demonstrated links between sexual abuse and disordered eating among women in college student and mental health samples. Little is known about such relationships among women from other samples or the relationship between other forms of childhood abuse as well as disordered eating (vomiting, starvation, laxative abuse). Prevalence of disordered eating was significantly higher among women who indicated a perceived childhood history of sexual, physical, or emotional abuse or who had personally witnessed violence.

Feminist theory has been instrumental in understanding the development of eating disorders among women (Fallon, Katzman, & Wooley, 1994; Gilbert & Thompson, 1996). One aspect of such inquiry has involved potential links between disordered eating and a history of childhood sexual abuse (see Connors & Morse, 1993; Everill & Waller, 1995; Pope & Hudson, 1991, for reviews). Sexual abuse and disordered eating typically have been studied among female college students (Baldo, Wallace, & O'Halloran, 1996; Kinzl, Traweger, Guenther, & Biebl, 1994; Smolak, Levine, & Sullins, 1990) or women being treated for either incest (Wonderlich et al., 1996), a clinical eating disorder (Fullerton, Wonderlich, & Gosnell, 1995; Gleaves & Eberenz, 1993; Tobin & Griffing, 1996), or some other psychiatric disorder (Vize & Cooper, 1995; Zlotnick et al., 1996). However, little is known regarding possible links between disordered eating and childhood sexual abuse

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among women other than college students or women in mental health treatment. Rorty, Yager, and Rossotto (1994) recruited a sample of women from the general community but did so through newspaper advertisements asking for women who had suffered from bulimia nervosa. Generalizing from that sample would be questionable.

Beyond reliance on nonrepresentative samples, the research to date has almost exclusively focused on childhood sexual abuse. Other forms of childhood abuse, such as physical and emotional abuse, physical neglect, and personally witnessing violence, have been relatively ignored. The purpose of the current study was to investigate possible relationships between five different types of childhood abuse and the prevalence of disordered eating among adult women from a nonmental-health setting.

METHOD

Participants

Participants were 147 women who presented for routine gynecological care to a female family physician in a health maintenance organization (HMO). Participants ranged in age from 18 to 49 years, with a mean of 34.0 years ($SD = 8.9$). Of the 147 women, 124 (84.4%) were White, 11 (7.5%) were Native American, 4 (2.7%) were Black, 2 (1.4%) were Asian, 2 (1.4%) were Hispanic, and the remaining 4 (2.7%) indicated some other ethnic identity. The majority of participants (65.3%) were currently married and had some post–high school education (61.9%).

Measures

Respondents were asked to indicate whether they had ever experienced any of five forms of abuse described in the questionnaire. Sexual abuse was defined for respondents as "any sexual activity against your will." Physical abuse was defined as "any physical insult against you that would be considered socially inappropriate by either yourself or others and that left visible signs of damage on your body either temporarily or permanently or caused pain that persisted beyond the 'punishment.'" Emotional abuse was defined as verbal and nonverbal behaviors with the purpose "of hurting and controlling you, not kidding or teasing you." Physical neglect was defined as "basic life needs not being met." Witnessing violence was defined as "first-hand observation of physical violence that did not directly involve you." For each form of abuse, respondents were asked to indicate the age range during which the abuse or trauma was first experienced. In the current study, only those experiences that occurred prior to age 18 were considered. Respondents also were asked whether they had ever "intentionally (i.e., on purpose)" engaged in self-induced vomiting, starving oneself, or abusing laxatives.

Procedure

The study was introduced to the potential research participants by a female family physician practicing in an HMO setting. Those who agreed to participate provided

Table 1

Percentage of Women ($N = 147$) Who Had Engaged in Disordered Eating Behavior as a Function of History of Childhood Trauma/Abuse

	Incidence of disordered eating			
Trauma	*Abused (%)*	*Not abused (%)*	χ^2	$p <$
Childhood sexual abuse	25.0	7.8	7.22	.008
Childhood physical abuse	25.9	8.3	6.67	.01
Childhood emotional abuse	20.0	8.4	3.82	.05
Childhood physical neglect	20.0	10.9	.75	.39
Childhood witnessing violence	25.0	5.8	11.18	.001

written informed consent and were taken to a private room to complete the questionnaire. Of 154 women invited to participate, 147 agreed and completed all measures (a 95.5% participation rate).

RESULTS

Of the 147 women, 32 (21.8%) reported having experienced childhood sexual abuse, 27 (18.4%) reported childhood physical abuse, 40 (27.2%) reported childhood emotional abuse, 10 (6.8%) reported physical neglect, and 44 (29.9%) reported witnessing violence. Incidence of any form of disordered eating was low: 17 (11.6%) women reported having engaged in at least one form (i.e., vomiting, starvation, or laxative abuse). The rates of disordered eating behavior as a function of abuse history are presented in Table 1. Note that likelihood of having engaged in disordered eating was greater among women who perceived childhood sexual abuse, physical abuse, emotional abuse, or witnessing violence, but was not greater among women indicating a perceived history of physical neglect. Depending on the type of abuse, disordered eating was two to four times more likely among self-identified abuse survivors compared to nonabused women.

DISCUSSION

Despite the relatively small sample size (and hence reduced statistical power), we found statistically significant associations among four different forms of childhood abuse and disordered eating. Others have noted the subsequent mental health implications of childhood sexual abuse (Browne & Finkelhor, 1986; Jumper, 1995), emotional abuse (Hart & Brassard, 1987), and physical abuse (Malinosky-Rummell & Hansen, 1993; Weaver & Clum, 1995), as well as other negative life events during childhood (Yang & Clum, 1996). It appears that future research should consider other forms of childhood abuse beyond sexual abuse in attempting to understand the developmental correlates of disordered eating among women.

The results of the current study need to be replicated with other community samples of women, as the current study was limited in several ways. For example, the childhood abuse variables were vaguely defined for respondents, making it impossible to determine the actual context of the perceived abusive experiences. We do not know the exact ages during which each respondent experienced the perceived abuse, the relationship of the perpetrator(s) to the respondent, the severity or frequency of the perceived abuse, and so forth. Similarly, we do not know whether the perceived sexual abuse involved a perpetrator who was significantly older than the respondent, whether the perceived physical abuse occurred in the context of punishment, or whether the perceived emotional abuse or witnessing of violence involved a caretaker. What we do know is that the female respondents in the current study who indicated a childhood history of abuse perceived certain events to have occurred. Factors affecting recall and labeling processes involving childhood abuse experiences are beyond the scope of this discussion, but are relevant to consideration of the current findings. Additional research is needed in which reliable, well-validated measures of abuse and disordered eating are used.

Despite crude measures of the relevant constructs (childhood abuse and disordered eating), the fact that statistically significant relationships emerged should prompt future researchers to consider several different forms of childhood maltreatment. Several obvious questions remain. For example, does binge eating qualify as a form of disordered eating? Does the nature and/or duration of the abuse matter or the relationship of the perpetrator to the child? Is some combination or interaction of particular forms of childhood abuse most predictive of disordered eating? Our sample size was too small to permit such an analysis, but future research, using larger and more representative samples, should consider such a possibility.

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