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## Associations Between Childhood Sexual Abuse and Binge Eating

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# ASSOCIATIONS BETWEEN CHILDHOOD SEXUAL ABUSE AND BINGE EATING

A Capstone Project submitted in partial fulfillment of the requirements for the degree  
Master of Arts in Clinical Psychology

Department of Psychology  
Western Kentucky University  
Bowling Green, Kentucky

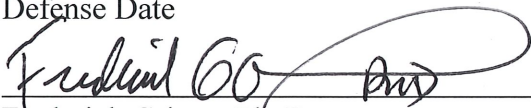
By  
Kristen Krogh

December, 2022

ASSOCIATIONS BETWEEN CHILDHOOD SEXUAL ABUSE AND EATING DISORDERS

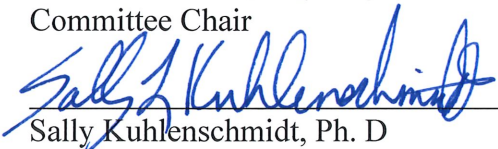
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Defense Date

A handwritten signature in black ink, appearing to read "Frederick Grieve", written over a horizontal line.

Frederick Grieve, Ph. D

Committee Chair

A handwritten signature in blue ink, appearing to read "Sally Kuhlenschmidt", written over a horizontal line.

Sally Kuhlenschmidt, Ph. D

Committee Member



## ABSTRACT

### ASSOCIATIONS BETWEEN CHILDHOOD SEXUAL ABUSE AND BINGE EATING

Childhood sexual abuse is the subject of many studies and analyses. Eating disorders, specifically bulimia nervosa, are also frequently studied to help clinicians gain an understanding of how they develop and the risk factors that make a person more susceptible than their peers. However, binge-eating disorder and its relationship to childhood sexual abuse is not as commonly researched. This paper seeks to investigate the literature available on the overlap between the two topics, childhood sexual abuse and binge-eating disorder. Then articles examining the relationship between the two will be identified and reviewed to determine the state of the literature. Finally, this paper will investigate the long-term impacts of childhood sexual abuse and binge-eating disorder (or patterns of disordered eating involving binging behaviors) to establish the importance of researching and understanding this topic.

Keywords: [childhood sexual abuse, eating disorders, binge-eating disorder, binge-eating behaviors]

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## Introduction

Much of the literature written about childhood sexual abuse focuses on the effects. Childhood sexual abuse, or CSA for short, is the unlawful sexual exploitation of a child to which they are unable to consent due to a lack of understanding and comprehension of what is occurring (Fuller-Thomson & Agbeyaka, 2020). This definition of CSA includes various forms of abuse, ranging from child pornography to nonconsensual touching to penetration. It is important to understand the impact childhood sexual abuse has on children as they grow and develop. CSA is a traumatic experience for a child to endure, and research endeavors have examined the long-term effects. Malecki et al. (2018) state that psychological distress can impact a child's relationship with food after they experience abuse. They assert that children who experience abuse struggle to regain a sense of autonomy and control over their body and do so through any mechanisms they can utilize. One such mechanism is through food, as most people who develop an eating disorder will also report feeling a lack of control elsewhere in their lives.

Eating disorders are also a common focus of research. Eating disorders are eating patterns that are characterized by severe and negative physical and emotional effects (Caslini et al., 2016). The fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2013) lists three major eating disorders. These include anorexia nervosa, bulimia nervosa, and binge-eating disorder.

Anorexia nervosa, or AN, is a pattern of disordered eating characterized by an intense fear of gaining weight. The diagnostic criteria for AN, as stated in the DSM-5 (American Psychiatric Association, 2013), include (a) restriction of energy intake relative to requirements that results in significantly low body weight (less than what would be considered minimally normal weight for adults or less than would be minimally expected for children and adolescents),



(b) intense fear of gaining weight or of becoming fat, or behaviors that persistently interfere with gaining weight despite being significantly underweight, and (c) disturbance in the perception of one's body weight or shape, undue influence of body weight or shape on self-evaluation, or lack of acknowledgement regarding the seriousness of current low body weight.

There are two subtypes of AN; one is the restrictive type, where the person limits their food intake, and the binge-purge type where the person partakes in binge episodes and follows up with a compensatory behavior afterwards. A binge episode is when a person consumes an amount of food that is unusually large for them in a short period of time, accompanied by feeling out of control (Pearson et al., 2014). Compensatory behaviors are any behaviors that are performed to "get rid of" the excess amount of calories consumed during a binge episode, and these can include self-induced vomiting, laxatives, diuretics, excessive exercise and fasting.

Bulimia nervosa, or BN, is similar to the binge-purge subtype of anorexia nervosa in that it is characterized by the same fears of gaining weight, as well as binge episodes followed by compensatory behaviors (American Psychiatric Association, 2013). The difference between AN and BN is that people with AN maintain a weight that is significantly less than a healthy ideal weight for their height, whereas people with BN maintain a weight in the range of normal or overweight. The diagnostic criteria for BN, as stated in the DSM-5 (American Psychiatric Association, 2013), include (a) recurrent episodes of binge eating, (b) recurrent compensatory behaviors that are performed to avoid gaining weight, (c) binge episodes and inappropriate compensatory behaviors both occur at least once a week for three months, (d) self-evaluation is unduly influenced by body shape and weight, and (e) the disturbance does not occur exclusively during episodes of AN.

Binge-eating disorder, or BED, is similar to BN and binge-purge AN in that it consists of binge episodes with feelings of being out of control. The diagnostic criteria for BED, as stated in the DSM-5 (2013), include (a) recurrent binge eating episodes, (b) binge-eating episodes are associated with eating more rapidly than normal, eating until feeling uncomfortably full, eating large amounts of food despite not feeling physically hungry, eating alone due to embarrassment of how much is being consumed, and feelings of disgust with oneself, depression, or excessive guilt after the binge eating episode, (c) marked distress about binge eating, (d) binge-eating episodes occur at least once a week for three months, and (e) the binge eating is not associated with recurrent use of compensatory behaviors as in BN and does not occur exclusively during the course of BN or AN. The key difference is that BED does not include compensatory behaviors to purge the excess calories consumed during the binge episode. This often results in people with BED becoming overweight or obese.

This paper will focus on bingeing behaviors and symptomology, and how these relate to CSA. Specifically, this paper will explore the association between these two topics, and will assume CSA is a precipitating event that leads to the onset of binge-related behaviors later in life.

## Method

For this paper, peer-reviewed journal articles that discuss childhood sexual abuse, eating disorders, and binge-eating behaviors were included if they are based on the fourth or fifth editions of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV [American Psychiatric Association, 1994] and DSM-5 [American Psychiatric Association, 2013]). Articles that discuss eating disorders other than food-based disorders (i.e., pica), as well as articles that discuss childhood abuse without mentioning childhood sexual abuse (i.e., physical and/or emotional abuse, but no mention of sexual abuse) were excluded. Articles cited in the references of other articles were included if they contained information relevant to the topic being discussed. Articles were excluded if they were not in English or available in full text (either via web page or PDF). There were no exclusions based on publication dates of the articles.

Articles were selected if they discuss studies featuring male and/or female participants of any age at the time of the study. These participants must have also experienced the abuse during their childhood (prior to 18 years old) to be included in this paper. Studies that used correlation, logistic regression analysis, and/or factor analysis were included. Data and information found through the research process for this paper were stored and organized using an Excel spreadsheet. Zotero was utilized to organize and implement citations. The selection process for these articles consisted of one reviewer, the author.

Databases included in the research process were PsycInfo, Psychology and Behavioral Science Collection, and Academic Search Complete. Research was conducted by using the following search terms and phrases: “childhood sexual abuse” AND “eating disorders OR disordered eating;” “childhood sexual abuse” AND “binge eating disorder OR bulimia nervosa OR anorexia nervosa.”

## **Results**

### **Database Search Results**

Using the search terms and selection process in the listed databases as outlined in the previous section, 338 articles were found. The articles were assessed by the author by reviewing the abstracts, and articles were selected to be included in the review if they discussed the overlap between childhood sexual abuse and binge-eating behaviors and symptoms. Articles were also selected for inclusion if they contained information that was relevant to either topic individually, such as providing background information. Articles were excluded from the review if they were not relevant to the topics being discussed. This includes if the articles did not discuss childhood sexual abuse in relation to binge-eating, or if they discussed one topic in association with other factors (i.e., childhood sexual abuse and other psychiatric conditions without mentioning eating disorders, or eating disorders in relation to childhood physical or emotional abuse without also mentioning sexual abuse). Sources listed in the reference section of found articles were included if they were relevant to the review and if the original source was accessible to the author. Other articles were excluded from the review if they were not peer-reviewed. As a result of the inclusion and exclusion criteria set for this review, 12 articles were selected for inclusion and used in this review.

## Figure 1

*Flowchart of included studies (n = number of articles)*



## Understanding the Prevalence of Childhood Sexual Abuse

In order to understand why exploring the connection between childhood sexual abuse and binge-eating behaviors is important, one needs to first understand the prevalence of CSA.

According to Fuller-Thomson & Agbeyaka (2020), about 3.5 million children were involved in investigations through Child Protective Services in the United States in 2019, which accounts for about 4.8 percent of the total number of children in the United States that year (Children's Defense Fund, 2021). Of all these cases, 8.6 percent (approximately 301,000, or 0.4 percent of the total number of children in the United States) were sexual abuse cases that were substantiated. Barth et al. (2013) state that estimations of how many children have experienced this across the globe vary for girls and boys, with 8 to 31 percent for the former and 3 to 17 for the latter. These statistics indicate that CSA is a common, widespread issue in the United States and globally.

Fuller-Thomson & Agbeyaka (2020) explored the factors that elevate the risk of a child experiencing CSA. In their study, Fuller-Thomson & Agbeyaka used two sets of data gathered

by the Centers for Disease Control and Prevention's (CDC) Brief Risk Factor Surveillance Survey (BRFSS) in 2010 and 2012. The data from 2010 was gathered by the CDC via phone interviews only with people who owned landlines, and participants who were at least 18 years old and were from Hawaii, Nevada, Vermont, Wisconsin, and the District of Columbia. In this set of data, there were 9,241 men and 13,627 women. The second set of data was gathered via phone interviews only with people who owned cell phones. These participants were at least 18 years old and were from Iowa, Tennessee, and Wisconsin. Of these participants, 11,656 were men and 18,145 were women. There were three measures used to interview each participant and get information. The Key Outcome Variable asked participants if anyone five years older than them or any adult had ever forced them to have sex while they were a child. This was to determine the participants' experiences with CSA. Another measure asked the participants about their exposure to other adverse childhood experiences (ACEs), and another set of questions attained demographic information about the participants, including age and ethnicity.

Fuller-Thomson and Agbeyaka (2020) found that three risk factors were associated with CSA. These risk factors were domestic violence, parental addiction, and parental mental illness. They found that even when only one of these risk factors were present in the child's life, it was predictive of CSA. For the women in the 2010 survey, CSA was 2.56 times more likely to have occurred in childhood ( $p < 0.001$ ) compared to women without any risk factors, and 3.36 times more likely for the women in the 2012 survey ( $p < 0.001$ ). For the men in the 2010 survey, they were 3.91 times more likely to have experienced CSA than men without any risk factors ( $p < 0.001$ ), and 2.31 times more likely for the men in the 2012 survey ( $p < 0.001$ ).

Malecki et al. (2018) state that psychological distress, such as childhood sexual abuse, alters the relationships children have with food and their bodies. They state that this leads to a

perceived loss of bodily autonomy, and as a result these children try to regain their control through the mechanisms to which they have access. Food is a common mechanism for control, as most people who develop an eating disorder also report feeling a lack of control over their lives. Vanderlinden et al. (2015) and Scheffers et al. (2017) hypothesize that eating disorders develop as a result of childhood sexual abuse, not because of a desire to be thin, but to be considered unattractive—to deter abusers from further violating them—and to punish their own bodies out of guilt regarding the abuse.

### **Childhood Sexual Abuse and Binge Eating**

Rabito-Alcón et al. (2021) conducted a systematic review to identify the mediating factors between various forms of childhood abuse and the development of eating disorders in general. They did this through a meta-analysis of the literature available on the subject at the time of their review. Their review was written using the Preferred Reporting Items for Systematic Reviews and Meta-Analyses method (PRISMA; Moher et al., 2009). Their search process used two American Psychological Association databases, PsycInfo and PubMed, and a combination of the terms “childhood trauma,” “eating disorders,” and “mediating factors.” Using this search process resulted in 319 studies and reviews, and the authors used 18 of these for their review. There was a total of 5,738 participants from all of the articles they used.

Rabito-Alcón et al. (2021), in a systematic review of the literature, found a number of factors played a role in the development of eating disorders following instances of childhood sexual abuse. Specifically, body dissatisfaction, self-criticism, depressive symptomology, alexithymia, anger, inefficiency, difficulty with emotional regulation, interoceptive awareness, food addiction, anxiety, dissociation, core beliefs, and symptoms of post-traumatic stress were all found to be mediating factors for eating disorders in general. The authors stated that self-

criticism impacts the severity of binge-eating in eating disorders in this population. Based on these findings, the authors concluded that sexual abuse that occurs in childhood is associated with the development of eating disorders later in life. As this article is a review and meta-analysis, it was included in this review as a starting point to name a few factors associated with childhood sexual abuse and disordered eating patterns that will be discussed later in this review.

Several articles identified for the current literature review concluded that childhood sexual abuse was a common factor in the childhoods of people with binge-eating behaviors. Armour et al. (2016) examined secondary data from a previously-conducted survey collected from October 2006 through December 2007 (National Centre for Social Research, 2007). This data was originally collected to assess the mental health of people who were 16 years old or older in England. The authors used the data of 3,845 participants to create their sample for their study. The data used in this study were the demographic information the participants provided, including age, marital status, ethnicity, and education; the participants' height and weight; information about childhood trauma; eating disorder symptomology; and information about posttraumatic stress disorder (PTSD), depression, and suicide attempts. The information about the participants' height and weight was used to calculate each participant's body mass index (BMI).

Armour et al. (2016) then used the BMI of the participants in the NCSR survey, as well as the symptomology of eating disorders that each participant reported, to divide the participants in the study into five distinct classes. Class 1 (N = 2,851) was for those who were of a normal weight and were non-symptomatic, and this class was considered the control group for the study as none of the participants reported any symptoms of eating disorders or weight outside of the normal range; Class 2 (N = 588) was for those who were obese but non-symptomatic; Class 3 (N



= 95) was comprised of participants who were morbidly obese; Class 4 (N = 144) contained those who were of a normal weight but symptomatic of eating disorders; and Class 5 (N = 167) consisted of participants who were obese and reported binge eating. It was found that the individuals in the study who experienced CSA were about twice as likely to be in Class 5 (OR = 1.98,  $p < 0.01$ ), and more than three times as likely to be in Classes 3 (OR = 3.07,  $p < 0.001$ ) or 4 (OR = 3.34,  $p < 0.001$ ) compared to the reference group, Class 1 (Armour et al., 2016). Therefore, the authors concluded that trauma is a significant predictor of eating disorder symptomology.

In one such study by Mason et al. (2013), it was found that CSA was linked to binge eating behaviors, obesity, and addiction to food. The authors used a modified version of the Yale Food Addiction Scale (YFAS; Gearhardt et al., 2009). The modified version (mYFAS; Flint et al., 2014) consists of nine items whereas the YFAS contains 25. Addiction to food is defined by the mYFAS as a person endorsing at least three out of seven symptoms that cause clinically significant distress or impairment: (1) distress concerning reducing the intake of certain foods at least four times a week, (2) consuming food even when one is no longer hungry at least four times a week, (3) negative emotions resulting from overeating that impair daily functioning at least twice a week, (4) fatigue or general sluggishness that is a direct result of overeating at least twice a week, (5) experiencing physical symptoms of withdrawal after reducing intake of certain foods twice a week, (6) eating the same amount of food despite the negative emotional and/or physical symptoms that result from overeating, and (7) increasing the amount of food consumed to reduce distress and withdrawal (Flint et al., 2014). Food addiction is a common characteristic of binge-eating disorder. The results of Mason et al. indicated that childhood abuse resulted in a greater risk for food addiction; the risk in Mason et al. (2013) was increased by 90% for women

with a history of childhood sexual abuse. Armour et al. (2016) and Mason et al. (2013) found that a history of childhood sexual abuse is linked to the development of disordered eating patterns later in life, including bingeing behaviors.

Another characteristic of binge-eating disorder is body dissatisfaction. Dunkley et al. (2010) conducted a study with 170 participants who were seeking treatment for weight loss, were overweight, and met the diagnostic criteria for BED according to the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV; American Psychiatric Association, 1994). They assessed the participants for childhood trauma, depressive symptoms, self-esteem, and body satisfaction. These were assessed using the Childhood Trauma Questionnaire (CTQ; Bernstein and Fink, 1998), the Depressive Experiences Questionnaire (DEQ; Blatt et al., 1976), the Rosenberg Self-Esteem Scale (RSES; Rosenberg, 1979), the Beck Depression Inventory (BDI; Beck et al., 1987), and the Body Shape Questionnaire (BSQ; Cooper et al., 1987). Fairburn (2008) stated that dissatisfaction with one's body image is notable as a clinical characteristic of binge-eating disorder and for treating eating disorders, meaning this particular trait is associated with the severity of binge eating behaviors. Understanding how one becomes significantly dissatisfied with their body was another goal of Dunkley et al. (2010) in this study. It was found that the correlation between sexual abuse and dissatisfaction with body image was significant ( $r = 0.18, p < 0.05$ ). Self-criticism was hypothesized to be the mechanism through which CSA, and other forms of maltreatment, lead to body-image dissatisfaction. This relationship was found to be significant as well ( $r = 0.45, p < 0.001$ ).

Body dissatisfaction was also studied by Wonderlich et al. (2000). The authors of this article conducted a study involving two groups of girls ranging in age from 10 to 15 years old. The first group consisted of 20 girls who were sexually abused, and the second group consisted

of 20 girls who had never reported being abused to serve as a control group. Among the girls in the first group, 35 percent had been abused once and 65 percent had been abused more than once. Additionally, five percent were abused before they were six years old, 65 percent were between 6 and 12 years old when they were abused, and 30 percent were between 13 and 15 years old. The authors used the CTQ (Bernstein and Fink, 1998), the Body Rating Scales for Adolescents (BRS; Sherman et al., 1995), the McKnight Risk Factor Survey (MRFS-III; Shisslak et al., 1999), and the Kids' Eating Disorders Survey (KEDS; Childress et al., 1993).

Wonderlich et al. (2000) found several factors among the girls who were sexually abused that were significantly more common than in the control group of girls. These factors included increased body dissatisfaction ( $p = 0.040$ ), frequent restriction of food intake ( $p = 0.042$ ), more stringent pursuit of thinness ( $p = 0.022$ ), increased purging behavior ( $p = 0.052$ ), and lower rates of perfectionism ( $p = 0.030$ ). The significance of this study, and by extension the information learned from the study, is the inclusion of children as the participants. This lowers the possibility that other factors could have led to the development of the girls' body dissatisfaction (as opposed to women who are included in studies like these as adults, who may have multiple reasons for poor body-image that they have accumulated throughout their lives). Therefore, this study provides the best evidence that childhood sexual abuse and disordered eating patterns are strongly associated with one another.

These studies by Wonderlich et al. (2000) and Dunkley et al. (2010) show that body dissatisfaction may be a connection between childhood sexual abuse and binge-eating behaviors. These studies showed that CSA is correlated with survivors becoming significantly dissatisfied with their bodies. Additionally, these studies indicate that CSA also is associated with the

likelihood of disordered eating patterns such as binge-eating. This disordered eating results in survivors feeling unhappy with the way their bodies look.

Guillaume et al. (2016) conducted a study that consisted of 192 female participants who were at least 15 years old (with a mean age of 24.92 years for the whole sample), and each was diagnosed with an eating disorder (anorexia nervosa, bulimia nervosa, or binge-eating disorder). Each participant was assessed by experienced clinicians and nutritionists for symptomology of eating disorders, and their functioning in the areas of occupation, autonomy, finances, leisure, and interpersonal relationships. The participants were also assessed for childhood trauma. The results of their study indicated that childhood abuse, including CSA, was significantly associated with the severity of eating disorders and a few of the key characteristics, including shape ( $p < 0.01$ ), daily functioning ( $p < 0.05$ ), food restriction ( $p < 0.01$ ), and overall concern with food ( $p < 0.01$ ). In other words, CSA impacted how the participants viewed and interacted with food.

Another study by Afifi et al. (2017) also looked at eating disorders in people who have experienced child maltreatment. This study used data that was collected from 2012 to 2013 by the National Epidemiologic Survey on Alcohol and Related Conditions Wave 3 (NESARC-III; U.S. Department of Health & Human Services, 2020). This resulted in a sample size of 36,309 participants whose information was collected via in-person interviews. The participants were required to be at least 18 years old (the mean age of the participants was 46.5 years old). Of the participants in this survey, 489 women and 128 men reported having any eating disorder, 240 women and 36 men disclosed having only anorexia nervosa, 71 women and 11 men reported having only bulimia nervosa, and 203 women and 82 men reported having only binge-eating disorder. The authors also reported the ethnicities of the participants in this study and classified them as either White or Other. Of those who reported having anorexia nervosa, 210 were White

and 66 were Other. Within the sample of participants who reported having bulimia nervosa, 45 were White and 37 were Other. In the binge-eating disorder group, 179 were White and 106 were Other. For the group of people who reported having any eating disorder, 415 were White and 202 were Other.

The results of the study by Afifi et al. (2017) concluded all forms of child maltreatment were associated with eating disorders. In regard to sexual abuse, the authors found that the men in the study who had experienced childhood sexual abuse also reported having an eating disorder; likewise, this same finding was noted for the women in the study. The authors noted that sexual abuse had the strongest relationship with the presence of eating disorders in both men and women. This is consistent with previous literature and studies. Afifi et al. (2017) noted some gender differences in their study. They stated that, in women, all of the types of child maltreatment and abuse that they included in their study—harsh physical punishment, physical abuse, sexual abuse, emotional abuse, emotional neglect, physical neglect, and exposure to intimate partner violence—were associated with increased instances of BED and binge eating behaviors, whereas for men only CSA and physical neglect were associated with BED and binge eating. For women, the connection between BED and CSA was significantly higher than in women without a history of binge-eating behaviors. After splitting the participants based on gender, Afifi et al. divided their participants into three groups to adjust for factors. For women in the first model, they were 2.57 times more likely than women without binge-eating behaviors to have a history of CSA ( $p < 0.001$ ). For the women in the second model, which was adjusted to factor in women with any mental disorder, they were 2.02 times more likely to have a history of CSA ( $p < 0.001$ ). The women in the third model, which was adjusted to include any mental disorder and all other types of child maltreatment, were 1.60 times more likely to have a history

of CSA ( $p < 0.05$ ). For the men in the first model, they were 2.21 times more likely to have a history of CSA than men without a history of binge-eating behaviors ( $p < 0.05$ ).

An article was found discussing the link between binge-eating disorder and childhood sexual abuse that also looked at the participants' ethnicity as a risk factor for developing binge-eating disorder (Striegel-Moore et al., 2002). The study consisted of 162 women with BED, 251 participants who did not have any psychiatric diagnoses, and 107 participants with other psychiatric disorders. In the group of women with BED, 102 were White women and 60 were Black women. The mean age for the White women in this group was 30.5 years and the mean age for the Black women was 30.1 years. Within the group of healthy participants, 164 were White women and 85 were Black women. In the group of psychiatric participants, 86 were White women and 21 were Black women. The participants were screened for eligibility through a phone interview. If they were deemed eligible, they were then invited to participate in another interview where they completed a diagnostic and risk factor assessment. The measures utilized in this study included a structured clinical interview, Eating Disorder Examination (Fairburn and Cooper, 1993), and an assessment of abusive experiences. They used chi-square analyses to assess for relationships of expected frequencies with abusive experiences and binge eating disorder.

Striegel-Moore et al. (2002) found that a third of the White women in the study and half of the Black women in the study with binge-eating disorder had experienced sexual abuse in their childhood. Additionally, Striegel-Moore et al. (2002) found a difference in the expected frequency of ethnic groups when it came to the development of BED. They stated that in their sample, CSA was not uniquely associated with BED in White women, but that for the White women in their study, CSA was associated with the presence of mental disorders in general.

However, they noted that for the Black women with BED in their study, the rate of CSA was significantly high (66.7 percent). Therefore, the authors of this study hypothesize that CSA could be a risk factor for developing BED in Black women. This suggests that there is a difference in the way children in different ethnic groups respond after enduring CSA.

### **Prognosis and Implications**

Knowing the long-term effects and prognosis for the people experiencing CSA is important to help understand the gravity of these conditions. Siegel and Sawyer (2019) discussed this in their study involving 70 women, ranging in age from 18 to 66 years old with an average age of 34.5 years old, who reported having an eating disorder. Each participant was interviewed and asked about their demographic information, current and previous occupations, and their eating disorder diagnosis. In this study, there were 64 White women, three Asian women, two Black women, and one Native American woman. The occupations of the women in this study varied immensely and include fields such as nanny, financial analyst, barista, teacher, dog groomer, manager, actor, waitress, and unemployed. The women interviewed had a variety of eating disorders, and they discussed the challenges that come with managing the disorder while working and trying to stay professional. The women were classified in one of the following categories based on their diagnosed eating disorder(s): Anorexia Nervosa , Bulimia Nervosa, BED, or Combination. The state of their condition was also recorded as one of the following: Active, Mid-Recovery, or Recovered. The women described stressors and experiences that were common among several of them, including work events where food was provided, discussions with coworkers about food or body image, and health incentive programs.

Siegel and Sawyer (2019) found through this study that the women managed the increased stress of coping with their eating disorder as a result of these situations through

avoidance and nondisclosure, and this was shown to be successful as a temporary solution. However, the authors stated that these created more issues or worsened existing issues for these women. For many of these women, the resulting effects involved triggering the symptoms of their eating disorders to become worse or, for the recovered individuals, to begin again as a way of coping with the stress and lack of support from peers. The authors suggested that behaviors such as mindfulness, sticking to healthy routines, and connecting with peers for support were more encouraging of better long-term outcomes, as the goal should be to prioritize recovery from eating disorders over work. It should be noted that this study was conducted through the use of clinical interviews, and as such there is no quantifiable data from this study to support this.

CSA and eating disorders often occur with other psychological disorders as well. A common comorbid disorder is borderline personality disorder (BPD; American Psychiatric Association, 2013). It is well-established that BPD often occurs in people who have endured childhood sexual abuse; this finding is supported in a study by Utzinger et al. (2016). Chen et al. (2010), in a systematic review and meta-analysis, found that eating disorder diagnoses are common in people who have a history of CSA. It is also reported by Caslini et al. (2016) in a systematic review and meta-analysis that binge eating is the most common symptom among CSA survivors. Utzinger et al. (2016) found that sexual trauma that occurs in childhood was associated with symptoms of BPD in participants who also had bulimia nervosa ( $F(1,131) = 12.83, p < 0.01$ ). Their study consisted of 133 women who met the diagnostic criteria for BN as outlined by the DSM-IV. The participants were between 18 and 55 years old, with an average age of 25.32 years old, and 97% of the participants were women. The authors used various measures for their study, including a structured clinical interview, the Diagnostic Interview for Borderlines-Revised (DIB-R; Zanarini et al., 2002), and the CTQ (Bernstein and Fink, 1998).



While this study affirms a connection between BPD, CSA, and BN, this article stated that binge eating is a common symptom among survivors of CSA.

It is also worth noting another long-term effect of childhood sexual abuse is the potential for revictimization that occurs for women later in life through intimate partner violence (IPV). As this review has illustrated, CSA is often associated with eating disorders, and Desai et al. (2002) and Messman and Long (1996) connected CSA to IPV via revictimization. The study by Desai et al. (2002) used data from 8,000 women and 8,000 men, for a total of 16,000 participants, to examine these relationships. The average age of the women in the study was 44.2 years old, and the average age of the men was 42.8 years old. There were 6,452 White women and 6,832 White men, 780 Black women and 656 Black men, and 628 women and 584 men who the authors categorized as one group, Other, comprised of participants who are Asian or Pacific Islander, American Indian, Alaskan Native, or multiracial. The participants were given two measures to assess adult victimization and childhood victimization, and they were asked about demographic information to control for other variables. Their results indicated that CSA was predictive of adult sexual revictimization by an intimate partner (AOR = 5.5,  $p < 0.05$ ). This means that a history of CSA made women 5.5 times more likely to be the victim of sexual abuse by an intimate partner. Messman and Long (1996) conducted a literature review on the relationship between CSA and revictimization. The authors found 25 studies that investigated this relationship, and the common finding of these studies was a connection between CSA and revictimization. Both Desai et al. and Messman and Long found that there was a relationship between CSA and revictimization through IPV in adulthood.

Kothari et al. (2015) conducted a study looking into revictimization. They conducted their study using data collected by the Avon Longitudinal Study of Parents and Children (Fraser

et al., 2013). The data of 13,761 pregnant women was used if the women were expected to give birth to their babies between April 1, 1991, and December 31, 1992. The women were asked if they had ever dealt with an eating disorder. Of the women who participated in the study, 82 indicated having a history of both AN and BN, 171 women reported having had only AN, and 199 disclosed having only BN. Kothari et al. asked the participants about current body image and any history of CSA. They also inquired about each participant's partner's reaction to their pregnancy.

The authors used four models to evaluate the associations between eating disorder prevalence and physical or emotional IPV. The fourth model was the only one of the four that was adjusted to include maternal CSA, so only the results of the fourth model are reported in this review. When evaluating for the associations between eating disorder prevalence without weight concerns or compensatory behaviors during pregnancy and physical IPV, women were 2.20 times more likely in the prenatal period ( $p = 0.05$ ) and 2.77 times more likely in the post-perinatal period ( $p = 0.001$ ) to experience physical IPV and have a history of eating disorders than women who did not have a history of eating disorders. For women who reported a history of eating disorders and also experienced weight concerns and/or compensatory behaviors, they were 2.61 times more likely to experience physical IPV than the women without a history of eating disorders in the post-perinatal period ( $p = 0.001$ ). When the authors assessed for associations between eating disorders and emotional IPV, they found that women who had a history of eating disorders without weight concerns or compensatory behaviors during pregnancy were 2.11 times more likely in the prenatal period ( $p = 0.001$ ) and 2.25 times more likely in the postnatal period ( $p < 0.001$ ) to experience emotional IPV. For women who had a history of eating disorders and experienced weight concerns and/or compensatory behaviors during pregnancy, they were 2.81

times more likely in the prenatal period ( $p < 0.001$ ), 2.25 times more likely in the postnatal period ( $p < 0.001$ ), and 2.48 times more likely in the post-perinatal period ( $p < 0.001$ ) to experience emotional IPV.

Through this, the authors found that the participant's partner's response, and a history of sexual abuse in the participant's childhood, were associated with eating disorders later in life and experiences of physical intimate partner violence for the women after they gave birth. Kothari et al. found that early experiences of sexual abuse increase the potential for revictimization later in life. They also found that both physical and emotional IPV were associated with lifetime disordered eating patterns and diagnoses.

## Discussion

This literature review found that CSA is often associated with the presence of disordered eating patterns, such as binge-eating behaviors and symptoms later in life. CSA has been shown to be associated with several symptoms and behaviors related to binge-eating. The connection between CSA and body dissatisfaction is found in the studies by Dunkley et al. (2010) and Wonderlich et al. (2000), as well as the meta-analysis included in the beginning of this review by Rabito-Alcón et al. (2021). These authors state that CSA appears to be associated with body dissatisfaction.

CSA is also associated with disordered eating patterns, such as binge-eating, that lead to a negative view of one's body due to weight gain. Dunkley et al. (2010) found that the participants in their study were all overweight, met the diagnostic criteria for BED (indicating that there were binge-eating behaviors present for all participants), and were all dissatisfied with their bodies. The authors also stated that a history of CSA correlated with body dissatisfaction for the participants as well. Armour et al. (2016) found in their study that CSA was related to binge-eating and weight gain, as a significant amount of the participants in their study with histories of childhood sexual abuse also fell in the categories of being obese or overweight. Additionally, Mason et al. (2013) found in their study that a history of CSA was common in participants with binge eating behaviors. In the case of the female participants in this study, the risk for displaying binge eating behaviors was increased by 90% when there was a history of CSA.

It is also important to acknowledge that establishing a link between a history of CSA and the presence of binge-eating behaviors does not determine the direction in which the relationship occurs. These articles present information that depicts CSA as a precursor to the development of disordered eating patterns; however, it is possible that this link is true in the opposite direction in

that disordered eating patterns—and the characteristics of these patterns, such as body dissatisfaction and self-criticism—could lead to children being more susceptible to abusers. Risk factors identified by Fuller-Thomson & Agbeyaka (2020), such as domestic violence, parental addiction, and parental illness, are predictive of CSA. This is likely because these factors produce children who do not have a strong support system to fall back on when they have problems or negative experiences. However, these could also be factors that make children more susceptible to eating disorders. Factoring in body dissatisfaction and self-criticism presents a child with binge-eating behaviors and a weak support system at home. If a child does not get the attention, support, and validation that they need at home, they will seek this out elsewhere. Abusers look for victims who are “easy targets,” in that the ideal victims for these abusers those who are looking for approval and validation and that are unlikely to tell anyone if they are being abused. These patterns repeat in adulthood as well, as Desai et al. (2002) and Kothari et al. (2015) found that a history of CSA makes both women and men more prone to revictimization in adulthood. One could speculate that a reason for this is that a history of being abused normalizes these patterns to the victim. There is still, presumably, a lack of support system for the victim to come to when they experience abuse, and this is still an ideal victim to an abuser.

Kothari et al. (2015) found in their study that women with a history of abuse and eating disorders are likely to be revictimized by an intimate partner once they become pregnant. There are some reasons for this that one can speculate upon as well. One such reason for the revictimization is that an abuser may view the victim as “locked in” once they become pregnant, as they now share a child and will therefore always have some form of contact and no way to completely cut contact and escape the abuser. The presence of an eating disorder is an interesting factor to consider, and it is unclear as to why women with an eating disorder were more likely to

experience IPV. One reason for this could be that, since self-criticism and body dissatisfaction are common characteristics in people with eating disorders, they may lack the confidence and positive self-esteem to leave an abuser for fear of never finding another partner and remaining alone.

### **Treatment Implications**

While it is not accurate to say that CSA is a direct cause of binge-eating behaviors, there is a connection between the two that makes it necessary for clinicians to understand the link. One implication for treatment that clinicians can take away from this literature review is the necessity to provide trauma-informed care and being cognizant of clients who have, or might have, a history of trauma, in this case CSA. Being aware of the overlap between CSA and binge-eating behaviors means the clinician will know to assess for each if a client discloses a history of one. Understanding the overlap also allows a clinician to provide care that is more connected with what the client needs. Providing trauma-informed care, such as trauma-focused cognitive behavioral therapy, will allow the clinician to address the trauma associated with a history of CSA directly. Since this review presents a link between CSA and binge eating in the context of the former preceding the latter, addressing the client's trauma before the disordered eating would be the best course of action. Addressing the root of a problem, in this case the CSA, will make addressing the effects of CSA easier for both the clinician and the client. However, should the eating disorder be life-threatening, the eating disorder should be addressed and treated by the clinician first as this is better for the client's immediate safety.

### **Future Research**

There were several topics in this area of research that are either under researched or would benefit from additional studies to give more credibility to the ideas presented. The study

by Afifi et al. (2017) noted significant gender differences. Specifically, they found that all seven types of child maltreatment in their study were associated with an increase in the instances of BED for women, however only CSA and physical neglect were found to have a strong association with increased instances of BED in men. This leaves an opportunity open for future studies to examine these gender differences and seek to find the potential causes.

Additionally, Striegel-Moore et al. (2002) found significant differences in the association between CSA and BED in the women in their study based on ethnicity. They found that CSA was more strongly correlated with instances of BED in Black women. They noted that the association between CSA and BED in Black women was significant enough that they proposed that CSA could be a specific risk factor. Future studies conducted on this topic should consider updating these statistics, as well as exploring the differences between ethnic groups.

Utzing et al. (2016) found that BPD commonly occurs in people with a history of CSA. Chen (2010) also connected BPD to eating disorder diagnoses. Both of these studies link CSA and eating disorders to BPD. Further studies conducted in this area should consider expanding on this link to see if there is a specific connection between binge eating and BPD. Researching a link between the three may allow clinicians to better help their clients manage and recover from these disorders. If a client presents with all three, it allows the clinician to have a more holistic understanding of the client and what they are going through. Addressing the client's struggles with BPD through the lens of it being based in trauma—such as the stormy relationships that commonly present in BPD cases—allows the client to receive trauma-informed care. As stated earlier, the binge-eating should be addressed first if it is an immediate threat to the client's health. Otherwise, it could be addressed as a result of BPD and CSA.

Kothari et al. (2015) conducted a study that examined the relationship between IPV, CSA, and eating disorders. They found that IPV was associated with a higher prevalence of eating disorders throughout the lifetime of the participants. This study examined the experiences of women during and after the perinatal period of pregnancy, and the authors acknowledge that this is the first study to do so. Therefore, future research should attempt to replicate this study. Additionally, future research in this area could look into the types of eating disorders among the women in the study to assess for relationships between specific eating disorders and the stage of pregnancy the IPV incidents occur, type of IPV, and frequency of IPV during pregnancy.



## **Conclusion**

Several studies have found a strong association between CSA and binge eating behaviors (Afifi et al., 2017; Armour et al., 2016; Guillaume et al., 2016). CSA appears to alter the relationship children have with food (Malecki et al., 2018). Scheffers et al. (2017) and Vanderlinden et al. (2015) hypothesized a desire to be unattractive to deter further abuse and to punish their bodies out of guilt, and not necessarily to be thin. Several mediating factors were found to play a role in the development of eating disorders in those with a history of CSA, including body dissatisfaction, addiction to food and eating, and symptoms of PTSD (Rabito-Alcón et al., 2021). Trauma was found by several studies (Afifi et al., 2017, Armour et al., 2016, Dunkley et al., 2010, Guillaume et al., 2016, Mason et al., 2013, Striegel-Moore et al., 2002, Wonderlich et al., 2000) to be a significant predictor of eating disorder symptomology and/or diagnoses, as it was a common occurrence in the histories of participants. Obesity, overeating, and body dissatisfaction are among the many common characteristics of eating disorders that occur in those that involve binge-eating behaviors, such as BN and BED. The result of this review indicates there is evidence for a strong association between CSA and binge-eating behaviors and symptomology.

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