BRIEF REPORT

Sexual abuse, bulimic symptoms, depression and satisfaction in adult relationships

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ABSTRACT. *This study explored the role of depression as a mediator between self-reported sexual abuse and bulimic symptoms. Secondly, the study examined whether there was an association between sexual abuse, bulimic symptoms, or depression and satisfaction in relationships and avoidance of sexual interactions. Women (n=297) who reported experiencing bulimic symptoms and/or depression and women who were not symptomatic completed measures on sexual abuse, bulimic symptoms, depression, satisfaction in partner relationships and avoidance of sexual interactions. A path model analysis indicated that there were direct relationships between sexual abuse and depression, depression and low satisfaction in relationships and avoidance of sexual interactions. Sexual abuse was not directly related to bulimic symptoms when depression was included in the model. Nor was sexual abuse directly related to relationship difficulties. The findings of this study support a model of non-specific pathways between sexual abuse and bulimic symptoms.*

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In early studies sexual abuse was identified as a potential risk factor associated with the development of eating problems in women (1). This early work raised the possibility that there was a casual link between sexual abuse and the development of eating problems such as anorexia nervosa and bulimia nervosa. Despite the obvious associations between abuse to the body and psychopathology, that has as a prominent feature body dissatisfaction, evidence to date has not been strong in supporting a direct link between sexual abuse and eating problems (2). This was clearly illustrated in a meta-analysis, conducted on 53 studies, where the direct association between sexual abuse and eating problems was only modest (3). Methodological shortcomings in the eating disorder research area (2, 4, 5) have restricted the conclusions that can be drawn about the link between sexual abuse and eating problems. Sampling problems have been twofold. Studies have investigated sexual abuse in clinical populations of women with eating disorders but did not include control groups. Or, women who presented to an eating disorder clinic were compared with "normal" control groups. The methodological limitations raise further doubts about whether a direct link between sexual abuse and eating problems exists. This is, in addition, supported by investigations where women with eating problems and women with other forms of psychopathology have been simultaneously compared on sexual abuse rates. Findings have indicated that no differences have been found between the two groups (6). In summary, sexual abuse may represent a non-specific risk factor for development of eating problems and this may explain why a direct link has not been evident.

Models testing pathways for indirect and direct links between sexual abuse and eating problems have shown that negative affect associated with the body (body disparagement) (7, 8) mediates between sexual abuse and body dissatisfaction. A limitation of testing a model with negative affect related to the body is that over emphasis is placed on the link between sexual abuse and the body. Negative affect unrelated to the body also needs to be examined. Psychopathology, such as depression, post-traumatic stress and anxiety (9) are consequences of experiencing sexual abuse and are unrelated specifically to affect about the body. Depression has been associated with sexual abuse (10) and bulimic symptoms (11). Depression may provide a means of testing an alternate model. One study that has investigated a model of mediation,

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without using specific affect associated with the body, demonstrated that internalized shame partially mediated between sexually distressing events and bulimic symptoms (8). It may be that affect in general mediates between sexual abuse and eating problems.

Not only may general psychopathology, in this case depression, explain the link between sexual abuse and eating problems but general psychopathology may also result in other risks such as interpersonal problems. A range of consequences, including interpersonal problems, have been reported to stem from sexual abuse (12, 13). Previous studies have indicated that women with eating problems have intimate relationship difficulties (14-16) and sexual problems (17). In addition, it has been frequently reported that depression is a risk factor for poor functioning in adult relationships (18). Two possibilities may explain these findings. The first is that sexual abuse, that has not been previously assessed, is the risk factor in the development of relationship difficulties in women with bulimic symptoms or depression. Alternatively, eating problems, depression and sexual abuse may all be associated directly with relationship difficulties.

The prevalence of reported episodes of sexual abuse in women ranges from 25% to 40% in community samples (19), to 54% in college women who reported some form of sexual victimization (20), and from 26% (6) to 39% (21) in clinical groups of women with eating disorders. The variability in frequency rates of reports of sexual abuse suggests definitions of sexual abuse vary considerably across studies (22). In recruiting participants for this study we did not specify that we were interested in sexual abuse, therefore we were more likely to find that we had an under representation of cases, rather than over representation of cases. Currently there is no method of asking participants about sexual abuse that has been recommended above another (6). In this study we relied upon anonymous self-report of abuse. Self-report has shown to be a valid method of asking adults to retrospectively recall sexual abuse (23).

The aims of this study were as follows:

1) To test the association between sexual abuse and bulimia nervosa symptoms using a large sample of women. Sexual abuse has been associated with both anorexia nervosa and bulimia nervosa (24); however, later studies have suggested that sexual abuse is more likely to be associated with bingeing, purging and body image disturbance, than with restrictive eating symptoms (25). Therefore in this study we examined bulimic symptoms.
2) To determine if there was a direct association between sexual abuse and bulimic symptoms, or if sexual abuse and bulimic symptoms were mediated by general affective difficulties, represented by depression. We examined a model with depression as the mediating variable between sexual abuse and eating problems.
3) To determine if there was a direct or indirect association between sexual abuse, bulimic symptoms and depression and low satisfaction and avoidance of sexual interactions in adult relationships.

MATERIALS AND METHOD

Participants and procedure

Women from the community (n=200), staff and students from a university campus (n=68) and women attending an outpatient clinic for eating problems and depression (n=35) answered an advertisement to complete a questionnaire for a study on relationships, eating problems and low mood. Women from the clinical sample volunteered to complete the questionnaires in the waiting room of an outpatient service. They did this anonymously. No other information was available on the clinical group. All participants were English speaking.

The age range of the sample was from 18 to 72 years with a mean age of 32.03 years (SD=12.54). All women in the clinical group, 55.9% of the university group and 78.5% of the community group had at some point in their life sought counselling. The majority of women had sought counselling for depressive symptoms. Fifty-seven per cent of women in the sample reported being currently in a close sexual relationship (n=171), and 42.3% reported not being in a current sexual relationship (n=126). There were 6 cases with missing data who were not included in subsequent analyses (n=297).

MATERIALS

Sexual abuse

Women were asked to report whether they had been sexually abused or harassed. Women were then asked to describe in writing the sexual abuse/harassment event(s) and the age at which this had occurred. The variables created for analyses were:

- Sexual abuse (yes, no). This category was determined by dividing the sample into those who had not reported sexual abuse/harassment (n=146) and those who had reported sexual abuse or harassment (n=151). The categorical variable for sexual abuse was used in the path analysis.

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- Severity of abuse: The descriptions of abuse were rated on a six-point scale from 1=no abuse or upsetting experiences, 2=regret for the event having occurred e.g., "I drank too much and had sex with someone", 3=one event that involved some force or coercion, "an ex-boyfriend when he was drunk pleaded with me to have sex", 4=multiple events that involved some coercion, "my partner was at times rough with me during sex", 5=one severe event that occurred once eg. "raped"; 6=events that were severe and occurred repeatedly eg., "abused by my uncle from ages 10-12 and raped at age 18". Two independent raters rated descriptions of sexual abuse or sexual mistreatment. An inter-rater reliability of 0.85 was recorded. Where raters disagreed the lower score was taken as the severity rating.
- Age of abuse: this category was also examined for cases where the abuse occurred under the age of 16 and cases where the abuse occurred at 16 years or older. Four groups were developed. A group of women with i) childhood sexual abuse (CSA) (n=31); ii) a group with adult sexual abuse (n=48; this was created by collapsing the ratings from categories 5 and 6); iii) a group of women with distressing sexual events (collapsing categories 2, 3 and 4; n=72); and iv) no sexual abuse group (n=146).

Bulimic symptoms

The Bulimia Test Revised (BULIT-R) (26) is a reliable and valid self-report measure of bulimic behaviour using the Diagnostic and Statistical Manual of Mental Disorders l-IV (DSM-IV) criteria which can discriminate between bulimic and non-bulimic groups and has demonstrated reliability and validity. The scale has shown predictive ability (26, 27) and good validity in university (28) and clinical groups (29). The cut-off score recommended by Thelen et al. of 104 places women into the clinical eating disorder range. This score has been shown to result in suitable predictive ability with very low false positive and false negative rates. In this study on the BULIT-R 41.1% (n=119) of the women reported scores under 60, 41.1% (n=119) of women reported scores between 60 and 104, and 17.8% reported scores over 104 (n=59).

Depression

The Beck Depression Inventory (BDI) (30) is a 21- item self-report assessment of depression which has resulted in good reliability and validity in community samples. Beck et al. report that, in community samples, scores above 20 identify individuals, moderate to severe depression with the severe depression range being from 29 to 63. In the current study 43.4% (n=129) of the women reported scores under 20, 50.5% (n=144) reported scores between 20 and 50 and the remaining 6.1% reported scores equal to or above 50. (n=24).

Satisfaction with relationships

Satisfaction with intimacy in relationships was measured by three questions asking about the closeness of relationships in general, expected satisfaction in any long-term relationships and overall satisfaction in relationships. These questions were employed because they significantly correlated with the Fear of Intimacy Scale (31, 32) and represented a brief measure of overall satisfaction with romantic adult relationships, as opposed to satisfaction with a current relationship. This enabled participants without a current partner to respond. Items were rated from 1=very dissatisfied to 6 =very satisfied and the mean of the three items represented satisfaction in general with intimate relationships. A factor analysis with principal components indicated that the three items loaded on one factor with factor loadings of 0.79, 0.81 and 0.85 explaining 66.79% of the variance. The three questions in this study recorded a Cronbach's alpha of 0.75. The reliability was low. This can be a function of the low number of items in the scale, therefore examination of the inter-item correlations provides a more accurate assessment of the internal consistency of short scales (33). The mean inter-item correlations should be between 0.2 and 0.4 to demonstrate adequate internal consistency. The mean inter-item total correlations for the three satisfaction questions were between 0.45 and 0.55. The mean score of the three items was used in analyses.

Avoidance of sexual relationships

Four questions were designed for this study in order to assess the degree to which women when they met a potential partner (they described their past behaviour if currently in a relationship) would be prepared to engage in a sexual interaction e.g., 'Do you tend to avoid sexual relationships'. The items were rated on a five-point likert scale from 1=unlikely to 5=very likely. A factor analysis with principal components indicated that the four items loaded on one factor with factor scores of 0.70, 0.64, 0.78 and 0.76, which explained 52.01% of the variance. The four questions in this study recorded a Cronbach's alpha of 0.70. The mean inter-item correlations were between 0.2 and 0.4 and demonstrated adequate internal consistency. High mean scores suggested individuals avoided sexual relationships. The mean score of the four items was used in analyses.

Demographic information

Participants were asked to indicate their age, educational status and history of seeking professional help. Participants currently in a partner relationship were asked to indicate in months and years the length of this relationship. In addition, women recorded their current weight in kilos and height in meters and body mass index (BMI, kg/m^2) was calculated.

Data analysis

Data were analysed using path analysis. The statistical program and the theoretical use of path analysis imply causality to some extent because of the direction of the arrows in the proposed model (34). Nevertheless the data collected in this study were cross-sectional so no assumptions of causality can be made. The results of the path analysis provide estimates of the size of relationships (i.e., effect sizes) between variables and tests of the fit of the model to the data. The standardized beta weights and the significance of each path can only be interpreted when the model demonstrates a good fit to the data. There are a number of fit indices traditionally used in the estimation of the fit of the model. The chi-square goodness of fit for the model, the Non-Normed Fit Index (NNFI), and the Root Mean Square Error of Approximation (RMSEA) were used to test the goodness of fit of the model. If the chi-square test for the overall model fit is non-significant this indicates a good fit to the data. A root mean square error of approximation RMSEA of 0.05 or less and a value above 0.95 on the NNFI indicates a good fit.

RESULTS

Preliminary analyses

A chi-square analysis was conducted with the sexual abuse group categories and the samples (university, community and clinical). There were no significant differences between the three samples $\chi^2(6)=8.26$, p=0.14. A chi-square analysis was also conducted on the severity of sexual abuse categories and women who reported currently being in a close partner relationship, and those who reported not being in a relationship. There were no significant differences $\chi^2(3)=2.44$, p=0.22.

Analysis of variance (ANOVA) was used to assess the differences between the severity of sexual abuse categories on BMI, BDI, the BULIT-R, satisfaction with relationships and avoidance of sexual relationships. ANOVAs indicated that there were no significant differences between the severity of abuse categories on BMI, satisfaction with relationships and avoidance of sexual relationships but there was a significant difference between groups on the BDI and a marginal difference between groups on the BULIT-R (Table 1). Post-hoc Tukey HSD tests indicated that there was a significant difference between the childhood abuse category and the no abuse category on the BDI.

Main analyses

Prior to conducting the path analysis all variables were checked for normality of distributions. Only the BULIT-R was skewed in a negative direction so a square root transformation was conducted. A path analysis using the statistical package AMOS was then used to test the model (Fig. 1). All direct links between variables were initially included, therefore the model was fully recursive and the fit statistics could not be tested. Nevertheless the path coefficients between sexual abuse (categorical variable) and satisfaction with relationships and sexual abuse and avoidance of sexual relationships were not significant so these paths were removed without compromising the theoretical or empirical bases for this study (we postulated that there may have been a fully or partially mediated relationship between sexual abuse and the relationship measures). The path

TABLE 1
Means, standard deviations, F and p values on the analyses of variance (ANOVAs) of the BDI, the BULIR-R, satisfaction with relationships and avoidance of sexual relationships across the four sexual abuse severity categories.

	Childhood sexual abuse		Adult sexual abuse		Distressing sexual events		No sexual abuse			
Variable	M	SD	M	SD	M	SD	M	SD	F	p
BULIT-R	80.42[a]	29.13	74.89	29.43	76.16	26.91	68.37[a]	27.93	2.45	0.06
BDI	30.31	16.07	27.00	15.72	26.43	14.87	22.65	13.33	3.32	0.02
Sat. Reln.	3.64	1.38	3.94	1.13	3.83	1.19	4.12	1.14	1.89	0.13
Av. Sex	3.42	1.07	3.16	1.00	3.02	0.89	3.13	1.08	1.19	0.31

Sat reln=satisfaction in relationships; Av. Sex=avoidance of sexual relationships; BDI=Beck Depression Inventory; BUILT-R=Bulimia Test Revised; [a]p<0.05

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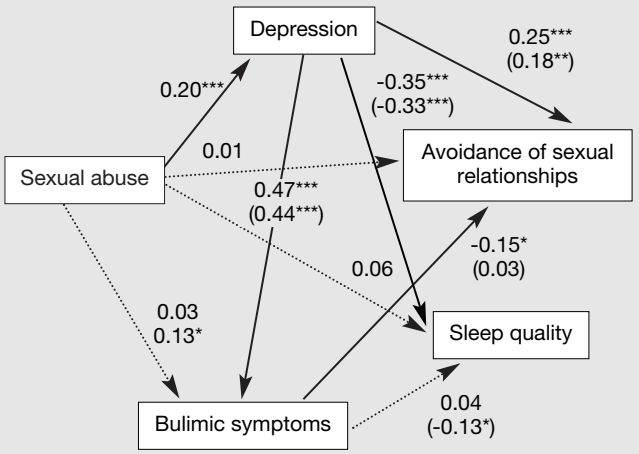

FIGURE 1

Path analysis with direct effects (Pearson's *r* univariate correlations and path coefficient between sexual abuse and bulimic symptoms when depression was removed from the equation) in parentheses and standardized path coefficients without parentheses on arrows. The dashed lines represent paths that were included in the model but were non-significant. The dotted lines represent paths that were removed from the final analysis.
*p<0.05, **p<0.01, ***p<0.001

coefficients between sexual abuse and bulimic symptoms and between bulimic symptoms and satisfaction with relationships and avoidance of sexual relationships were also not significant, however these paths were retained in order to test the links between bulimic symptoms and the other variables.

A second analysis of the model was then conducted (Fig. 1). The fit statistics for the model indicated that this final version was a good fit to the data. The chi-square was not significant, p=0.068, the RMSEA was below 0.05 (p<0.000) and NNFI was above 0.95 (0.99). Finally, the model was re-run and depression was removed from the analysis. This analyses indicated a significant path co-efficient between sexual abuse and bulimic symptoms (0.13, p=0.05). The model in Figure 1 indicates all path co-efficients on arrows and Pearsons' *r* correlations in parentheses next to the path co-efficients. The removed paths and non-significant paths are indicated by the broken line arrows. There was a significant path between sexual abuse and depression which mediated between sexual abuse and bulimic symptoms. There were significant paths between depression and low satisfaction in relationships and avoidance of sexual relationships. There was also a significant negative path between bulimic symptoms and avoidance of sexual relationships which was not evident in the Pearson's *r* correlations.

DISCUSSION

Childhood sexual abuse was associated with higher levels of depression in this study than the no abuse group. The adult sexual abuse and the distressing sexual events groups fell in between. There was also a marginal finding along similar lines for bulimic symptoms where significance was not reached. The sexual abuse groups were not significantly related to satisfaction in relationships or avoidance of sexual relationships. It is therefore possible that abuse experienced in childhood may be more likely associated with depression than sexual abuse experienced in adulthood. Earlier work has highlighted the risk that childhood sexual abuse has in terms of the risk of associated psychopathology (10). There is also a possibility that an individual who has experienced childhood abuse has multiple sexual abusive experiences across their life span (35) which results in higher risks for the development of psychopathology, including eating problems (21). Despite the higher risk for depression, childhood sexual abuse, in this study, was not associated with an increased risk for low satisfaction in adult relationships, or avoidance of sexual interactions. There are two possibilities that may explain these findings. Women with childhood sexual abuse or with adult sexual abuse were not less likely to be in a close intimate partner relationship. Therefore women in this study may have had higher protective factors and lower risk factors that enabled them to function adaptively in relationships. The second possibility is that the measures of satisfaction in relationships and avoidance of sexual relationships, which were developed for this study, did not discriminate sufficiently between the groups.

In the path analysis sexual abuse was significantly associated with depression and bulimic symptoms but when both were placed in the model at the same time only depression remained significant. Depression therefore mediated between sexual abuse and bulimic symptoms. Depression was also significantly related to bulimic symptoms. Due to the cross-sectional data collection and the circular nature of this study, it is not possible to determine whether sexual abuse is primarily associated with bulimic symptoms, or whether sexual abuse is primarily associated with depression. The temporal sequence of events is also impossible to determine. A limited conclusion can be made that women who were both depressed and experiencing bulimic symptoms were more likely to have reported sexual abuse. Childhood sexual abuse was shown, in a recent study, not to be directly related to

adult depression. The association between childhood sexual abuse and depression was mediated by cluster B personality disorder symptoms and a dysfunctional childhood (10). In general, this highlights the complexities of relationships between risk factors and protective factors associated with sexual abuse.

Depression, but not bulimic symptoms, was also associated with low satisfaction in relationships and avoidance of sexual relationships in this study. There was a negative univariate relationship between bulimic symptoms and satisfaction with relationships but this path became non-significant when depression was included in the model. This suggests that if women are depressed and experiencing bulimic symptoms then they report low satisfaction in relationships and that if they are depressed they are more likely to avoid sexual relationships. Depression has been implicated both theoretically and empirically with problematic relationship functioning (18, 36, 37).

Finally, there was a negative pathway between bulimic symptoms and low avoidance of sexual relationships in the path analysis when depression was included.

This finding indicated that when depression (which predicted more avoidance of sexual relations) was controlled for, the presence of bulimic symptoms was predictive of less avoiding of sexual relations. Reference has been made to the difficulties women with bulimic symptoms experience in terms of their own boundaries with others due to their desire to please and be accepted by others (38) and more specifically the tendency to seek out multiple sexual interactions (17). The tendency to seek out sexual interactions raises the issue of whether women with bulimic symptoms, particularly those with fewer depressive symptoms, are exposing themselves to risky sexual interactions.

In summary, the current study attempted to provide further knowledge on the association between sexual abuse and bulimic symptoms. The empirical support for a direct link has been limited but this study demonstrated that an indirect link may explain the association between the two. The study utilised a large sample of women with a wide age range and good spread on the variables of interest. There were large enough numbers in this sample to test the model presented. The findings provide tentative support for depression, or psychopathology in general, playing a role in the link between sexual abuse and bulimic symptoms.

Limitations of the study include the cross-sectional nature of data collection, particularly in relation to retrospective recall of sexual abuse and the associated demand characteristic that may result from completing questionnaires on depression, bulimic symptoms and relationship functioning. In addition, women were asked to describe in their own words their sexual abuse experiences. The uncertainty of the accuracy of the self-report information highlights the need for careful interpretation of the findings in this work. Future work should focus on the temporal associations between sexual abuse, depression and bulimic symptoms. The contextual elements of sexual abuse including the age of abuse, the degree of violence of the abuse, the closeness of the perpetrator of the abuse and repeat victimization in relation to abuse should be examined in connection with the specific symptoms that develop either in relation to depression, or in relation to bulimic symptoms.

Overall findings supported a non-specific pathway from sexual abuse to bulimic symptoms which in this study was mediated by depression.

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