

CALIFORNIA STATE UNIVERSITY, NORTHRIDGE

CHILDHOOD TRAUMA AND INFLUENCE ON EATING DISORDERS

A graduate project submitted in partial fulfillment of the requirements for the degree of Master
of Science in Counseling, Marriage, Family Therapy

By

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Dedication

This is dedicated to my family, friends, and instructors for the love and support provided through my educational journey.

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ABSTRACT

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A greater amount of empirical research utilizing adult (Buhsnell, Wells, & Oakley-Brown, 1992; Dansky, Brewerton, Kilpatrick, & O'Neil, 1997, Garfinkel et al., 1995 Pribor & Dinwiddie, 1992; Steiger & Zankow, 1990; Wonderlich, Donaldson et al., 1996; Wonderlich, Wilsnack, Wilsnack & Harris, 1996) and child (Brewerton, Ralston, & Hand, 1998; Wonderlich et al., in press) samples, evoke that a history of child abuse is associated with disturbances in eating. Several studies reveal a connection between other forms of maltreatment and eating disorders (Rorty, Yager, & Rossotto, (1994), implying that childhood trauma, described broadly, might be linked with eating disturbances. A current review of this literature concluded that childhood sexual abuse seems to be a considerable risk factor for bulimia nervosa, specifically when there are increased degrees of psychotic comorbidity is present (Wonderlich, Brewerton, Jovic, Dansky, & Abbott, 1997). Therefore, in response to the necessity for additional information and training on the relationship between eating disorders and child abuse, the project's curriculum is designed to increase knowledge among graduate students in marriage and family therapy. The literature review explores the diagnosis, co-morbidity and morality rates, epidemiology, historical context and the link among abuse and eating disorders.

Chapter 1

Introduction

Eating disorders are abrasive and incapacitating psychiatric disorders, expressed by disturbances in eating behavior and body image. Anorexia nervosa (AN) and bulimia nervosa (BN) are the two main types of eating disorders. The main characteristics of both disorders incorporate a persistent quest of thinness, an over worry with body weight, shape and size and a distorted discernment of one's own body. Eating disorder not otherwise specified (EDNOS) is a diagnostic category provided by the DSM-IV to code individuals who meet some but not all the criteria for anorexia nervosa or bulimia nervosa.

People with anorexia nervosa, bulimia nervosa and eating disorder not otherwise specified engross in an extensive arrange of eating disordered actions mainly to regulate food intake and control body weight. A lot of these behaviors may also work as coping methods, which aid to regulate troubled feelings and thoughts. Examples of eating disordered behaviors comprise binge eating, self-induced vomiting, restricting food, over-exercising and the misuse of laxatives/diuretics, all of which are employed in varying patterns and combinations.

A history of childhood trauma, specifically sexual (CSA), physical (CPA) and emotional abuse (CEA) and neglect, is usual in this population. Individuals with anorexia nervosa, bulimia nervosa and eating disorder not otherwise specified that claim childhood trauma often engross in self- destructive behaviors (Nagata, Kiriike, Iketani, Kawarada, & Tanaka, 1999; Costorphine et al., 2007).

Moreover, research advocates that eating disordered acts and self-destructive acts may be utilized to deal with the thoughts and emotions related with past trauma (Briere and Scott, 2007;

Fullerton, Wonderlich, & Gosnell, 1995).

Furthermore, people with eating disorders usually have comorbid psychiatric disorders such as anxiety, depression and substance use disorders (Hudson, Hiripi, Pope & Kessler, 2007; Dansky, Brewerton, Kilpatrick, 2000). Psychiatric comorbidity has likewise been discovered to be high in those with eating disorders who report trauma histories (Kong & Bernstein, 2009; Carter, Bewell, Blackmore & Woodside, 2006; Anderson, LaPorte, Brandt & Crawford, 1997).

It is of clinical significance to define whether a history of childhood trauma influences the appearance of eating disorder symptoms and overall psychopathology in individuals with eating disorders. Therefore, the content of this project literature review incorporates research on how eating disorders can be described and classified, the risk factors and dangers of developing eating disorders, how views of the body image have altered over the course of time, as well as perceiving eating disorders in light of cultural aspects. In the following chapter, the clinical features related with Anorexia Nervosa, Bulimia Nervosa and Eating Disorders Not Otherwise Specified are revised, in addition to the epidemiology of these three disorders. Subsequently, clinical characteristics linked with childhood sexual, physical and emotional abuse as well as childhood emotional and physical neglect will be examined. Finally, the literature concerning the association of eating disorders and childhood trauma will be presented.

Statement of Problem

Marriage and Family therapists are among the professionals who are the first line of support for clients with trauma and eating disorders. These MFT's are at the forefront of dealing with abused clients whether with children or adults. Eating disturbances impacts performance and increases health and safety risks. In therapy, clinicians need to be aware of the relationship

among eating disorders and abuse. It is important they know the current data on the topic. Moreover, there is a lot of research that implies a connection among the two; however, this literature has been limited by a variety of methodological problems (e.g., inadequate definitions of childhood abuse, small sample sizes, and absence of adequate control groups) that limit the strength of the inferences that can be concluded. Furthermore, these studies have not been able to use psychometrically sound interview measures to measure the presence of eating disorders. Consequently, it can be deduced that this lack of information may ensue in a lack of access to adequate psychotherapeutic interventions as issues go undisclosed or unnoticed.

Significance

This project addresses the necessity for knowledge, illustrated by Marriage and Family therapists, on matters of trauma and eating disorders and on child abuse as associated with eating disorders. The thesis project will generate and arrange an illustration of issues for the expansion of consciousness in regards to eating disturbances and the negative influence of child abuse. Therefore, it is vital to address how to inquire support and treatment as a solution to the negative consequences that childhood trauma has on eating disorder clients.

The project presents an educational method to educate about this topic. The objective of this project is to generate an educational Power Point presentation to augment the knowledge between graduate students in the field of marriage and family therapy and other professionals of childhood trauma and its association to eating disorders. This increased knowledge intends to enhance the grad student's receptiveness to learn about early assessment, to enable clients with childhood trauma access to suitable aid, treatment and resources.

Lessening the waiting time that childhood abuse victims may seek to access treatment and support resources help to reduced possible chances of trauma, intrapsychic struggle and thus eating disorders. The predictable positive outcomes of early intervention may donate to client's views. Therapy will help clients understand that these behaviors are an essential survival mechanism until they are able to live in a more optimistic and emotionally vigorous manner. Moreover, they will acknowledge that their eating disorder was a definite gift for progress and learning in all facets of life. Likewise, comprehend that these behaviors were an effort to deal with their emotions relating to abuse or to purify the body of feelings of repugnance. Overall, they will learn not to criticize and know they cannot alter the past, but instead can vigorously decide to move onward and work to mend from their trauma, retrieving a sense of personal control and learn to cherish and love their body again.

Purpose of the Project

The purpose of this project is to create and apply a Power-Point presentation to be made available in a webpage (<http://web.ebscohost.com.libproxy.csun.edu>). The Internet website is intended to be accessed primarily by California State University Northridge (CSUN) MFT, graduate students and staff. The website's educational curriculum sections will grant MFT students a research based presentation including the areas of: early trauma and eating disorders, child abuse, moreover; diagnosis, co-morbidity, morality rates, epidemiology, historical context, and cultural factors of eating disorders.

Definition of Terms

Eating Disorders (EDs):

Anorexia Nervosa (AN) (Binge-Purge type): According to the DSM-IV-TR (2000) Anorexia Nervosa of the Binge-Eating/Purging type consists of an individual regularly engaging in binge-eating or purging (i.e. self induced vomiting or the misuse of laxatives, diuretics or enemas) during a current episode of Anorexia Nervosa.

Bulimia Nervosa (BN) (Purging Type): When an individual regularly engages in self-induced vomiting or the misuse of laxatives, diuretics, or enemas during a current episode of Bulimia Nervosa (DSM-IV-TR, 2000).

Bulimia Nervosa (Nonpurging Type): Occurs during a current episode of Bulimia Nervosa when an individual has used other inappropriate compensatory behaviors, such as fasting or exercise, but has not regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas (DSM-IV-TR, 2000).

Childhood Abuse (CA):

Childhood Physical Abuse (CPA): A physical assault or physical boundary violation involving physical contact leading to an intentional and identifiable physical injury and/or intimidation of the victim in a person under the age of 18 (Root and Fallon, 1988).

Childhood Sexual Abuse (CSA): non-contact incidents such as making the victim watch pornography, sexual comments or coercions directed at the victim, and watching the victim get dressed or using the bathroom, as well as interactive experiences such as touching the victim in a sexual way, making the victim touch the perpetrator in a sexualized way, molesting and rape.

Childhood Emotional Abuse (CEA): verbal abuse, for instance having been screamed at, critiqued and chastened, threatened, controlled, disregarded and blamed.

Childhood Emotional Neglect (CEN): neglecting a child's emotional needs, for example by suppressing love, and failing to inspire growth and learning.

Childhood Physical Neglect (CPN): incidents in which a child's physical needs are neglected, for instance through the lack of food, clothing and medical care or a deprivation of supervision.

The following chapter will cover the literature review. This includes classification of eating disorders, definitions and diagnosis, epidemiology, comorbidity and mortality, historical context, culture-ethnicity-and eating disorders, classification of childhood trauma, childhood trauma and eating disorders, Childhood Sexual Abuse (CSA) and eating disorders, CSA and eating disorder symptoms in non-clinical populations, CSA and eating disorder Symptoms in clinical populations, Childhood Physical Abuse (CPA) and eating disorders, CPA and eating disorder symptoms in non-clinical and clinical populations, Childhood Emotional Abuse (CEA) and eating disorders, CEA and eating Disorder symptoms in non-clinical and clinical populations and finally Childhood Emotional and Physical (CEN) Neglect and eating disorders.

Chapter 2

Literature Review

Classification of Eating Disorders

Definitions and Diagnosis

The most current version of the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition, text revision, (American Psychological Association, 2000) categorizes Eating Disorders (EDs) into three subtypes: Anorexia Nervosa, Bulimia Nervosa, and Eating Disorder Not Otherwise Specified. EDs are described by severe disturbances in eating behavior (APA, 2000). Dieting is characterized as the habit of consuming food in a controlled fashion to attain or preserve a regulated weight (Wikipedia, 2009). EDs differentiate from dieting in that they are sterner in time and intensity and typically cross a line of what is thought as healthy and rational. Nevertheless, facts have demonstrated that dieting behavior augments the chance for EDs (Nielsen, 2001) and numerous cases of eating disorders are led by dieting (Fedoroff &McFarlane, 1998).

Furthermore, both Anorexia Nervosa and Bulimia Nervosa differentiate from dieting in that they comprise a troubled perception of body weight and shape. AN is characterized by: 1) a refusal to maintain a minimally normal body weight, 2) intense fear of gaining weight or becoming fat, even though underweight, 3) a disturbance in perception of one's own body, and 4) the absence of at least three consecutive menstrual cycles in postmenarcheal females (amenorrhea). The DSM-IV-TR (2000) moreover categorizes Anorexia Nervosa into Restricting types and Binge-Eating/Purging types.

The dissimilarity among Anorexia Nervosa Restricting and Binge-Purge types is the existence or absence of constant binge-eating and purging throughout a present anorexic state.

Bulimia Nervosa is described by recurrent episodes of binge-eating followed by inappropriate compensatory behaviors such as self-induced vomiting; misuse of laxatives, diuretics, or other medications; fasting; or excessive exercise, at least twice a week for three months. During a binge episode, an objectively large amount of food is consumed and the eater feels out of control of the eating behavior. The DSM-IV-TR (2000) also subdivides Bulimia Nervosa into Purging and Non-purging types. An Eating Disorder Not Otherwise Specified refers to any disorder of eating that does not meet criteria for either of the preceding two specific Eating Disorders or their subtypes.

Recent reports evoke that in the approaching DSM-V, ED categories will be more detailed and accurate (DeAngelis, 2009). An example is the recent prerequisite for amenorrhea in order to be diagnosed as AN. While this categorization is beneficial for a particular subset of women with Anorexia, it does not account for men, women on birth control, or women with Anorexia Nervosa who do not miss their periods (DeAngelis, 2009), making it more problematic to reach at a diagnosis of Anorexia in particular populations. Furthermore, recent reports from the Eating Disorders Work Group developing the novel DSM-V criteria propose that binge-eating disorder will be implemented as a diverse category (DeAngelis, 2009). Additional developments might also encompass how to justify for cultural variables with Eating Disorders, how to diagnose children with Eating Disorders, and more exact descriptions of words such as "binge" (DeAngelis, 2009).

The clinical characteristics of Anorexia Nervosa comprise perfectionism, social anxiety, rigidity, over activity, obsessiveness, and the need for control fluctuating with episodes of

impulsiveness (Wilson, Becker, Heffernan, 2003). The clinical factors of Bulimia Nervosa are parallel to those of Anorexia Nervosa, such as feelings of intense guilt, shame, and severity of thinking. Even though dissimilarities occur between Anorexia Nervosa and Bulimia Nervosa, such as those with Bulimia Nervosa predominately being in the average weight range and less resilient to treatment than those with Anorexia Nervosa (Wilson et al., 2003), there are more parallels than dissimilarities.

Epidemiology

The onset for Anorexia Nervosa typically happens in adolescence between the ages of 14-18 (Wilson et al., 2003). With Bulimia Nervosa, the onset has a broader array, from adolescence to early adulthood. Whereas the occurrence rates differentiate to some extent among comprehensive research, they are usually stable. In the United States the occurrence rates for females with Anorexia Nervosa have been found to be between 0.2 to 0.5 % (Nielsen, 2001; Wilson et al., 2003). The occurrence rates for Bulimia Nervosa are a bit more, between 1-2% in females and 0.1% in males (Nielsen, 2001; Wilson et al., 2003). Samples from France obtained occurrence rates for Bulimia Nervosa to be comparable to those in the United States; 1.1% in women and 0.2% in men (Nielsen, 2001). Figures from Norwegian areas conveyed occurrence rates of 0.4 % for Anorexia Nervosa and Bulimia Nervosa rates of 1.1% in females (Nielsen, 2001). It is crucial to remember that the existing occurrence rates for eating disorders are miscalculated because of both the private nature of the disorders and the great number of individuals who have subclinical onsets for the disorders.

The prevalence of females with Anorexia Nervosa was shortly quoted as 8 per 100,000 and 0.5 per 100,000 in males (Nielsen, 2001). The prevalence rates of Bulimia Nervosa were established to be 13 per 100,000 females (Nielsen, 2001). In clinical samples 5-10% of eating

disorder patients were recognized as male (Wilson et al., 2003). Several of the studies obtained on sexual orientation and eating disorders has been questionable, even though homosexuality in males has been quoted as a greater risk aspect for eating disorders due numerous men's provenance on thinness in the gay culture (Wilson et al., 2003). Likewise, a probable explanation about the emergence of Eating Disorders and the discrepancies among genders is the role of socializing males to express their symptoms while females are trained to internalize their symptoms. This can enlighten why both genders underwent physical abuse but males are more liable to carry on the cycle of abuse and become offenders whereas females are more liable to internalize their symptoms and acquire Eating Disorders.

The proportions of college students with Eating Disorders are reasonably greater than the rest of the population. Within western cultures 14% of White students, 2.7% of Asian students, and 3-4% in African American students have Bulimia Nervosa (Fedoroff & McFarlane, 1998). In spite of Latino students presently encompassing around 13% of the college students in the US, this population was not considered for in Fedoroff and McFarlane's research. In comparison to nonwestern societies such as Japan (.005-.04%) and Hong Kong (.46%) the rates of EDs in students was much less (Fedoroff & McFarlane, 1998). Nonetheless, eating disorders appear to be rising cross-culturally (Wassenaar, le Grange, Winship et al. 2000; Miller & Pumariega, 2001).

Comorbidity and Mortality

A staggering 97% of inpatient eating disorder clients portrayed more than one comorbid diagnosis (Blinder, Cumella, & Sanathara, 2006). Mood disorders, specifically unipolar depression was designated in 94% of the Eating Disorders patients (Blinder, et al., 2006). Anxiety disorders were the second most usual comorbid disorder, found in 56% of the examined

population, followed by substance disorders in 22% of the partakers (Blinder, et al., 2006). BN presented greater rates of alcohol abuse and polysubstance abuse out of all the Eating Disorders subtypes. In binge-purge type Anorexia Nervosa Obsessive-Compulsive Disorder, Posttraumatic Stress Disorder and Schizophrenia were twice as probable to co-occur than in other Eating Disorders categories (Blinder, et al., 2006). These outcomes prop exceedingly high degrees of comorbid psychiatric disorders in Eating Disorders patients.

Research obtained in regards to mortality degrees in eating disorders seems very mutable, even though there is accord in that eating disorders have extremely high mortality degrees when compared with other psychiatric diagnoses (Walsh, Wheat, & Freund, 2000). Eating Disorders seem to have one of the greater mortality degrees of any psychiatric disorder, for instance the mortality rate due to Anorexia is twelve times greater than the morality rate for people between 15 and 24 years of age (Sullivan, 1995; Walsh et al., 2000). Nielson (2001) quotes raw mortality degrees for Anorexia Nervosa to be at 5.9% (178 deaths per 3,006). Of this 5.9% mortality degree 54% died from eating disorder difficulties, 27% from suicide, and 19% from unidentified or other causes (Nielsen, 2001). Additional studies quote Anorexia Nervosa's mortality degree to be at 10% (Wilson et al., 2003) or as high as 15% (Walsh et al., 2000). Mortality degrees for Bulimia Nervosa are significantly less than Anorexia Nervosa and there is much complexity directly connecting the cause of death to Bulimia Nervosa, raw mortality degrees from Bulimia Nervosa arrey from 1-3% (Quadflieg & Fichter, 2003). In longitudinal research mortality degrees were typically at 2.8% after a two-year follow-up, 2.1% after 4.5 years follow-up, and 2.2% after 10 years follow-up (Quadflieg & Fichter, 2003). BN ranged from .03% (7 deaths per 2,194 people) to 20% (Nielsen, 2001).

Historical Context

Eating Disorders are not a current phenomenon and countless types of Eating Disorders can be outlined all through history. In prehistoric eastern religions, spiritually inspired austerity leading to self-starvation similar to Anorexia (Miller & Pumariega, 2001). Ancient Christians who were referred to as "Gnostic cults" participated in intense fasting as a response in contradiction to hedonism and materialism (Miller & Pumariega, 2001). Thru the Middle Ages and the early Renaissance, women utilized spiritually inspired self-starvation to gain sainthood in the Roman Catholic Church (Miller & Pumariega, 2001).

Rudolph Bell in his book *Holy Anorexia* (1985) assesses the existence of Anorexia Nervosa between women in the Roman Catholic Church. Bell invented the term "holy anorexic," in reference to women who displayed the standards that met today's meaning of an eating disorder, but credited the anorexic acts as a means to become more allied to God. Bell explicates the complex prodigies of "holy anorexia" as part of a bigger battle in contrast to a patriarchal culture. Women who were capable to repel food and water were perceived as being capable to defeat the physical drives of the sin teeming world. Bell quotes such saints as "Catherine of Siena, Veronica Giuliani, Mary Magdalen de' Pazzi, and Margaret of Cortona" as women who fit under the grouping of "holy anorexia." Many of the 250 Italian women Bell clarified participated in the anorexic acts as a way of self-punishment.

Even though these illustrations from history have a lot of similarities to the exposition of eating disorders it's vital to remember that these illustrations seem to differentiate on inspirational natures, in that the central incentive of Anorexia Nervosa is a worry of obesity and irrationality around appearance, on the contrary to starvation as a method to a religious purpose. Nonetheless, it is problematic to ascribe probable psychological incentives as little to no data

was chronicled on the historical expositions of eating disorders.

Far along, in the 17th and 18th centuries perceptions on self-starvation altered from "holy" to being "possessed by the devil" and thereafter to perceiving those involved in this behavior as deceptions and physically or mentally sick (Miller & Pumariega, 2001). In approximately the 19th century the "tubercular" view became fetishized as dazzling. It was not till the late 19th century that Anorexia Nervosa was accepted as a medical disorder (Miller & Pumariega, 2001).

The history of Bulimia Nervosa can be drawn back to ancient Egyptians who engrossed in medically sanctioned purging (Miller & Pumariega, 2001). In old Rome customary vomiting was performed by the affluent in "vomitoriums" which were assembled for people to gulp emetics and vomit following eating (Miller & Pumariega, 2001). Even though Bulimia has roots dating as far back as old Egypt and Rome it was not classified as a distinct diagnostic unit until 1979 (Miller & Pumariega, 2001).

Therefore, are Eating Disorders a result of a historical period's social constrains? Several from the Feminist view would perceive eating disorders as a "social disease" (Seid, 1994). Seid (1994) noted that the female body has not altered, but the idyllic of the female body type has, along with the approaches and determination employed to reach that idyllic. An alternate hypothesis is that perfect body types imitate the principles of present society and that as history changes, also do the principals and standards about body types (Derenne & Beresin, 2006).

In the 15th century, gothic cathedrals exhibited extremely thin women in ceiling canvas (Seid, 1994). During the 16th century painters in Northern Europe changed to painting thinner than normal females in the nude. Colonial times in America were stern and thus prized

physically sturdy, capable, and fertile women (Derenne & Beresin, 2006). In the 17th century thinness was not associated to health and strength as it is currently, but with fragility and brittleness (Seid, 1994). It seems that the idealism of skinny waists and slenderness was a luxury for the wealthy at this time period and that, overall, slender women were perceived as ugly. Actually, inflatable under-garments were invented and worn by thin women (Seid, 1994).

Throughout the 17th Century the principles were different from today's body type ideals. Fat was related with a "stored up force" for vigor and strength, and represented suitable nature and health. Conversely, there was a change from 1800's to 1900's when thinness came into style (Seid, 1994). From the 1830s through the 1850s women struggled for the little waist flaunted by Scarlet O'Hara in *Gone with the Wind* (Seid, 1994). Seid (1994) suggests that the change can be accredited partially to the Modernists' aesthetic for decreasing things down to their fundamental forms. Corsets were the pinnacles of 19th century fashion, where the idyllic of small waists with large breasts continued. It was supposed that flimsiness made women more attractive for marriage (Derenne & Beresin, 2006).

With the commencement of feminism, a boyish, non-curvaceous skinny trend came into fashion around the 1920's denoted to as "flapper fashion" (Russell & Treasure, 1989; Derenne & Beresin, 2006). Soon after, World War II began and with men absent over seas, cherished body types in the United States allied with strong, capable and bright women (Derenne & Beresin, 2006). Nevertheless, when the men came back from war, the standards soon changed towards customary gender roles, cherishing curvaceous bodies that represented fertility (Derenne & Beresin, 2006). With postwar freedom and plenty in the U.S., a dread grew of Americans becoming ethically and physically lean. A "fat phobia" followed with a worry around fat (animal fat specifically) that lead Americans to become ill and unhealthy (Seid, 1994). The 1960's were

an era of sexual liberty and struggling for women's rights when the prewar principles of boyish figures became "in" again, feasibly with the body as a symbol for parity (Derenne & Beresin, 2006). By the 1960's the "standard" body size for women became perceived as overweight (Seid, 1994). Seid (1994) related the current approaches concerning food and body shape to Victorian era taboos about sex and contemporary approaches. Seid (1994) leaves readers with the query of whether cultures continuously create some form of power in order to feel refined.

Presently, women are blasted with varied messages from the media in regards to the perfect body types; the super thin run way model, big breasted supermodels with thin waists, and fit and sturdy athletes. A prevalent lay perspective of eating disorders faults the media for propagating unrealistic body outlooks. In the 1980's the typical fashion model was 8% skinnier than the "normal" woman (Derenne & Beresin, 2006).

Currently, the typical model is 23% skinnier than the "normal" woman (Derenne & Beresin, 2006). Additional props for the media's encouragement on body image is the Becker study lead in 1995. Becker et al. (2002) studied ethnic Fijian adolescents pre and post the overview of western television to their country. Becker et al. (2002) discovered that extended exposure to television had an adverse influence on eating behaviors and approaches in television guideless teenage girls. Previous to the study the percent of teenage dieting was at 0%, after the deluge of television this number ascended to 69% (Becker et al., 2002). The view that everyone can attain this "idyllic weight" with sufficient determination has shifted society towards a "censure the victim" stance (Seid, 1994). Fat has become associated with disgrace and griminess, whereas thinness is associated with purity and self-esteem, which tries to fit America's self-aid philosophy (Seid, 1994).

Culture, Ethnicity, and Eating Disorders

The data on culture, ethnicity and eating disorders seems to sustain varied perspectives and numerous views. Though some researchers propose that Eating Disorders are a culturally compelled condition, others find that with women of different cultural upbringings, eating disorders imitate a coping mechanism for transitioning to a novel culture (Fedoroff & McFarlane, 1998; Wassenaar, le Grange, & Winship et al., 2000; Miller & Pumariega, 2001; Palmer, 2007). Additional studies imply that the typecast of eating disorders as a western marvel is a product of the lack of research on a variety of populations and locations (Wassenaar, le Grange, Winship et al. 2000).

The influence of culture on Eating Disorders can be associated via examinations on Western versus Eastern countries. One study contrasting Western countries (United States and France) to Eastern countries (India and Tibet) revealed no substantial dissimilarity in eating pathology when all aspects were controlled (Rubin, Gluck, & Knoll, et al, 2008). In Rubin et al.'s study (2008), girls from the United States had less body image inconsistencies than Tibetan girls. Tibetan girls had the greatest body image inconsistencies, desiring to be bigger than their actual body size. It is probable that the upsurge in body image inconsistencies is due to the linkage between social class and upbringing.

Classification of Childhood Trauma

Numerous children bear disturbing behaviors of maltreatment that have extensive consequences on their physical and psychological well-being. Childhood sexual, physical, emotional abuse, and childhood neglect are all types of child maltreatment (Mash & Wolfe, 2005). The occurrence rate of child maltreatment in Canada is 9.7 cases per 1000 children

(Trocmé & Wolfe, 2001). Furthermore, the DSM-IV-TR has dedicated a small segment of the Axis I category “Other conditions that may be a focus of clinical attention,” to childhood sexual and physical abuse and childhood neglect (APA, 2000). Nevertheless, sexual, physical and emotional abuse, and childhood neglect are all generally reported in clinical sites.

Child trauma has been described in diverse ways throughout the literature because of the absence of accord over how aspects such as age and severity of trauma ought to be included into definitions of trauma. The Childhood Trauma Interview by Fink, Bernstein, Foote, Lovejoy, Ruggiero, & Handelsman (1993) is generally utilized at clinical sites to evaluate numerous types of childhood trauma. The descriptions of trauma utilized for the Childhood Trauma Interview were based on a detailed review of the childhood trauma literature. Fink et al. (1993) defined six types of childhood trauma, four of which relate to this study: 1) sexual abuse, 2) physical abuse, 3) emotional abuse and 4) physical neglect. Childhood sexual abuse was defined as non-contact incidents such as making the victim watch pornography, sexual comments or coercions directed at the victim, and watching the victim get dressed or using the bathroom, as well as interactive experiences such as touching the victim in a sexual way, making the victim touch the perpetrator in a sexualized way, molesting and rape (Fink et al., 1993).

Moreover, Fink et al. (1993) described Childhood Physical Abuse as incidents, in which the child is hit, beaten, kicked, tossed against walls, locked in closets, burned, strangled, and cut. Childhood Emotional Abuse is described as verbal abuse, for instance having been screamed at, critiqued and chastened, threatened, controlled, disregarded and blamed. Lastly, physical neglect is described as incidents in which the victim was unsupervised by the perpetrator, and denied of food, clothing and medical care (Fink et al., 1993).

The Childhood Trauma Questionnaire (CTQ, Bernstein & Fink, 1998), a self-report tool

of childhood trauma resulted from the Childhood Trauma Interview, describes a history of childhood emotional neglect utilizing these five elements on the self-report measure: “1) there was someone in my family who made me feel important or special, 2) I felt loved, 3) people in my family looked out for each other, 4) people in my family felt close to each other and 5) my family was a source of strength and support.” The creators of the CTQ assert that minute ratifications of these five elements are related with childhood emotional neglect (Bernstein & Fink, 1998). These five sorts of childhood trauma are related with numerous psychiatric troubles such as the development of anxiety and depression, complexities in sexual adjustment, criminal and antisocial acts as well as eating disorders (Mash & Wolfe, 2005).

Childhood Trauma and Eating Disorders

People with Eating Disorders frequently report histories of childhood trauma (Rorty, Yager & Rossotto, 1994; Van Gerko, Hughes, Hamill & Waller, 2005; Wonderlich et al., 2007). Therefore, many studies have focused on detecting relationships among eating disorders and reported childhood trauma, mainly sexual, physical and emotional abuse (Anderson, LaPorte & Crawford, 2000; Rorty, Yager & Rossotto, 1995; Fullerton, Wonderlich & Gosnell, 1995; Wonderlich et al., 2007). Moreover, a history of childhood trauma in people with eating disorders has been related with an upsurge in risk taking actions such as alcohol abuse, suicide efforts, self-harm and shoplifting (Fullerton, Wonderlich & Gosnell, 1995; Claes & Vandereyken, 2007).

There have been different explanations set forth to explain why people with a history of childhood trauma would consequently develop an eating disorder or engross in eating disordered acts (Schwartz & Gay, 1996). For example, Briere and Scott (2007) state that eating disordered acts are both direct consequence and coping retorts to childhood abuse. An illustration of a direct

result of childhood abuse incorporates struggling for an unrealistic body type through dieting or confining food consumption, as a consequence of a destroyed self-esteem and weak body view due to abuse. On the other hand, coping retorts are acts utilized to control distress and tension related with trauma. They propose that binge eating and purging help to numb individuals of any adverse emotional feelings or judgments felt as a response of the trauma and therefore serve as coping consequences.

Furthermore, it has been implied that self-induced vomiting, confining food consumption and laxative misuse can grant forms of bodily regulations for victims of sexual abuse including the lack of control over ones own body (Schwartz & Gay, 1996; Briere & Scott, 2007). Additionally, a lot of weight loss behaviors such as confining and purging might play a part in preventing the emergence of a feminine body to evade forthcoming sexual relationships (Schwartz & Gay, 1996). The precise purpose of each type of eating disorder act might differ from individual to individual, but typically the symptoms are perceived as assisting the individual to uphold psychological balance.

Childhood Sexual Abuse and Eating Disorders

Incidence studies show that about 30% of individuals with Eating Disorders report histories of Childhood Sexual Abuse, which is parallel to other psychiatric populations (Pope & Hudson, 1992; Connors & Morse, 1993; Steiger & Zanko, 1990; Oppenheimer et al., 1985; Rorty & Yager, 1996). For instance, Root and Fallon (1988) discovered that 28% of their eating disorder patient population reported a history of Childhood Sexual Abuse. Nevertheless, results from incidence studies differ due to the utilization of diverse methods and the variety of descriptions of sexual abuse that remain in the literature. Presently, the relationship between eating disorders and Childhood Sexual Abuse does not seem to be causal; nonetheless, the

literature does propose that this sort of abuse might serve as a non-specific risk feature for psychiatric troubles (Wonderlich, Brewerton, Jovic, Dansky & Abbott, 1997; Wonderlich, Wilsnack, Wilsnack & Harris, 1996).

Various studies have found that a history of Childhood Sexual Abuse is more predominant in bulimic conditions, such as Bulimia Nervosa or Anorexia Nervosa Binge-purge Subtype, in comparison to restrictive conditions such as Anorexia Nervosa Restricting Subtype (Carter et al., 2006; Van Gerko et al, 2005; Oliosi & Dalle Grave, 2003; Wonderlich et al., 1997). Studies have also associated sexual assault throughout adulthood to Bulimia Nervosa (Dansky, Brewerton, Kilpatrick & O'Neil, 1997). Carter, Bewell, Blackmore & Woodside (2006) studied 77 anorexic patients admitted to an eating disorder inpatient clinic. The partakers were tested on measures of eating disorder symptoms and additional psychiatric conflicts as well as childhood sexual abuse histories. The results showed that a considerably higher number of inpatients diagnosed with the binge-purge subtype of Anorexia Nervosa conveyed a history of CSA (65%) in comparison to those diagnosed with the Restricting Subtype of Anorexia Nervosa (37%).

Likewise, Oliosi & Dalle Grave (2003) compared rates of Childhood Sexual Abuse between individuals diagnosed with the Purging Subtype of Anorexia Nervosa, the bingeing subtype of Anorexia Nervosa and the Restricting Subtype of Anorexia Nervosa. They found that those diagnosed with Anorexia Nervosa Binge Subtype (20%) and Anorexia Nervosa Purge Subtype (34.2%) reported more Childhood Sexual Abuse in comparison to those diagnosed with Anorexia Nervosa Restricting Subtype (7.5%).

A clinical study by Van Gerko et al. (2005) studied histories of Childhood Sexual Abuse and eating disorder acts in women with different eating disorder diagnoses. A lower rate of

women with Anorexia Nervosa Restricting Subtype (16.1%) reported Childhood Sexual Abuse in comparison to those with Bulimia Nervosa (30.4%) or Anorexia Nervosa Binge-purge Subtype (29.5%). Moreover, through all diagnostic groups, bulimic acts such as bingeing, vomiting, laxative and diuretic abuse were conveyed more often by those who underwent Childhood Sexual Abuse in comparison to those without this trauma history. Consequently, individuals with eating disorders frequently report histories of Childhood Sexual Abuse. This is particularly accurate of individuals with bulimic syndromes.

Childhood Sexual Abuse and Eating Disorder Symptoms in Non-Clinical Populations

It has been implied that a history of Childhood Sexual Abuse is related with particular eating disorder symptoms. The studies below emphasize research results on the linkage amongst Childhood Sexual Abuse and eating disorder symptoms in non-clinical populations.

A study by Wonderlich, Wilsnack, Wilsnack & Harris (1996) evaluated a national sample of 1099 US women on amount of Eating Disorder behaviors and past trauma. The outcomes from this study disclosed that more women with a history of Childhood Sexual Abuse (19.1%) engrossed in binge eating in comparison to those who did not report Childhood Sexual Abuse (7.8%). Wonderlich et al. (2000) compared eating disturbances in 20 children with histories of CSA to a control group of 20 children who did not report a history of trauma. The conclusions designated that purging acts, dieting and weight discontent all happened at a considerably higher degrees in the group of children who had undergone Childhood Sexual Abuse. Likewise, Ackard and Neumark-Sztainer (2003) evaluated the occurrence of Childhood Sexual Abuse in 81,247 high school students. Those who reported a history of Childhood Sexual Abuse were two times more liable to binge-eat or fast, four times more liable to vomit or utilize diet pills, and five times more liable to utilize laxatives in comparison to the non-abused group of female students.

Lastly, Sancu et al. (2008) evaluated the connection amongst Childhood Sexual Abuse and the later start of eating disorder symptoms in a longitudinal study including 1936 grade 9 female student partakers. The students were tracked and evaluated for eating disorder symptoms utilizing the DSM-IV occasionally until they were about 24 or 25 years old. Childhood Sexual Abuse was evaluated by asking the partakers whether or not they had ever undergone any unwelcomed sexual experiences engaging an adult or older person before the age of 16. The findings implied that females who reported more than two incidents of Childhood Sexual Abuse were more than four times more liable to acquire purging behavior among the ages of 16 and 17 years old than those with no Childhood Sexual Abuse. Moreover, females who reported two or more incidents of Childhood Sexual Abuse were more than three times more liable to acquire binge-eating behaviors among the ages of 16 and 17 years old in comparison to those who did not report Childhood Sexual Abuse. These studies demonstrate that Childhood Sexual Abuse is linked with a wide array of eating disorder symptoms in non-clinical populations.

Childhood Sexual Abuse and Eating Disorder Symptoms in Clinical Populations

People diagnosed with Eating Disorders in clinical settings usually report Childhood Sexual Abuse. A history of Childhood Sexual Abuse has been linked with more severe depression, anxiety, obsessive-compulsive aspects, general psychiatric disturbances and higher degrees of treatment dropout in this patient population (Carter et al., 2006). Furthermore, the origin of this sort of trauma has been proposed to augment the incidence of eating disorder behaviors in individuals diagnosed with eating disorders. The defined research in this segment scrutinizes the connection amongst Childhood Sexual Abuse and eating disorder behaviors in clinical populations.

In a study by Waller (1992b), bulimic women reporting a history of CSA were

discovered to binge more often in comparison to those without a trauma history (mean of 10.3 vs. 6.69 binge episodes/week). Childhood Sexual Abuse was assessed utilizing the Sexual Events Questionnaire by Calam and Slade (1989) and through clinical interview, both of which asked about unwanted sexual experiences (including rape, attempted rape, exposure and fondling) throughout the participant's lifetime. In accordance with many other studies (Hastings & Kern, 1994; Baldo & Baldo, 1996; Waller, 1992a), the results of this study disclosed that the definite origin of the abuse was associated to the sternness of bulimic symptoms. In specific, individuals who were sexually abused before the age of 14 reported a higher occurrence of bingeing compared to those who were abused at a later time (mean of 11.9 vs. 6.4 binge episodes/week). Moreover, individuals abused by a relative also reported a higher occurrence of bingeing compared to those abused by a non-relative (mean of 16.9 vs. 4.62 binge episodes/week). In additional study, Waller (1992a) assessed a sample of 54 women with Eating Disorders and examined Childhood Sexual Abuse utilizing the same measures and criteria as Waller (1992b) cited above. Those who reported the highest incidence of binge-eating were either sexually abused by family members or were sexually abused at an early age; as well as bulimic women who reported the highest incidence of vomiting were sexually abused by family members.

A study lead by DeGroot, Kennedy, Rodin & McVey (1992) examined Childhood Sexual Abuse histories in outpatients with Anorexia Nervosa and Bulimia Nervosa. Childhood Sexual Abuse was examined utilizing the Diagnostic Schedule for Eating Disorders (DSED), which asked partakers "have you ever been sexually abused against your will (incest, rape)?" (DeGroot et al., 1992). The Eating Disorder Inventory and the Eating Attitudes Test were utilized to examine the eating disorder symptoms. The findings revealed that reported Childhood Sexual Abuse in this outpatient sample was related with considerably higher overall scores on the Eating

Disorder Inventory (EDI) and the Eating Attitudes Test (EAT).

Waller, Halek & Crisp (1993) assessed the eating behaviors and childhood abuse histories of 100 female patients diagnosed with Anorexia Nervosa. These researchers measured sexual occurrences while interviews conducted at examination or in treatment. There were no identified age limits in defining Childhood Sexual Abuse, and the interviews emphasized the unwelcomed nature of the sexual abuse. More patients with a history of Childhood Sexual Abuse reported vomiting and abusing laxatives in comparison to those without this trauma history (56% vs. 12%). Dissimilar to Waller (1992a and 1992b), this study did not discover a linkage among bingeing and Childhood Sexual Abuse, which implies that possibly this association relates mainly to individuals with Bulimia Nervosa.

Wonderlich et al. (2007) examined the association between Childhood Sexual Abuse and eating disorder psychopathology in 123 women with Bulimia Nervosa. These researchers utilized the Childhood Trauma Interview by Fink et al. (1993) to examine histories of trauma and the Eating Disorder. A study by Fairburn and Cooper (1993) used the Ecological Momentary Assessment (EMA) to examine present eating disorder symptoms. The conclusions disclosed that Childhood Sexual Abuse was not linked with any symptoms measured by the EDE, nonetheless, it was considerably related with purging frequency on the EMA.

Overall, reports on Childhood Sexual Abuse and eating disorder symptoms have exposed that a history of Childhood Sexual Abuse does effect the presentation of eating disorder symptoms in both clinical and non-clinical populations. Nevertheless, due to discrepancies in the literature this linkage still remains uncertain. Firstly, preceding studies examining Childhood Sexual Abuse and eating disorder behaviors have utilized different definitions of Childhood Sexual Abuse. Secondly, the measures utilized to examine Childhood Sexual Abuse also differ

from study to study, from short questionnaires to thorough and lengthy interviews. Finally, very limited studies ask about the role of Childhood Sexual Abuse on eating disorder behaviors. Thus, a validated examination measure and a more consistent definition of Childhood Sexual Abuse would help prospect research in this subject.

Childhood Physical Abuse and Eating Disorders

There have been limited studies about Childhood Physical Abuse and eating disorders. Nevertheless, several studies have discovered that numerous individuals with eating disorders report histories of Childhood Physical Abuse (Williamson, Thompson, Anda, Dietz & Felitti, 2002; Bailey & Gibbons, 1989; Rorty, Yager & Rossotto, 1994).

Root & Fallon (1988) found that 29.1% of an outpatient bulimic sample with a history of binge eating and bulimic behavior reported a history of Childhood Physical Abuse. Likewise, Claes & Vandereyken (2007) examined a sample of eating disorder patients and found that 32.3% reported a history of physical abuse. An additional study by Fullerton, Wonderlich & Gosnell (1995) assessed 712 female eating disorder patients on measures of child abuse. Roughly 25% of the patients reported Childhood Physical Abuse.

Moreover, Brown, Russell, Thornton and Dunn (1997) compared eating disorder inpatients, outpatients, and patients at family physician offices on measures of childhood abuse. They discovered that 34% of the inpatients, 16% of the outpatients and only 5% of the normal control patients reported a history of CPA. Lastly, Nagata, Kiriike et al. (1999) examined childhood abuse histories in 235 Japanese patients with eating disorders. Considerably more patients with anorexia nervosa binge-purge subtype and bulimia nervosa reported histories of childhood physical abuse than those with anorexia nervosa restricting subtype (23% and 19%

versus 0%). Nagata, Kaye, Kiriike et al. (2001) duplicated this outcome in an American sample of patients with eating disorders.

Childhood Physical Abuse and Eating Disorder Symptoms in Non-Clinical and Clinical Populations

Studies directed in non-clinical populations demonstrate that Childhood Physical Abuse is linked with eating disorder symptoms and a greater sternness of these symptoms. For example, Bailey & Gibbons (1989) administered self-report questionnaires to 294 female university students and concluded that a history of Childhood Physical Abuse was considerably connected with the sternness of bulimic symptoms.

Reto, Dalenberg and Coe (1993) discovered that 32% of their university student sample reported a history of Childhood Physical Abuse and that the severity of the Childhood Physical Abuse reported was linked with the severity of binge eating and purging behavior as designated by scores on the bulimia subscale of the Eating Disorder Inventory (EDI). More precisely, individuals with a higher severity of Childhood Physical Abuse (a greater degree of violence, frequency, etc) scored higher on the bulimia subscale of the EDI than those reporting a less severe form of Childhood Physical Abuse, and this was mainly true for the men of the sample. Childhood Physical Abuse was examined with the 12 item Violence History Questionnaire by Dalenberg (1982).

Neumark-Sztainer, Story, Hannan et al. (2000) examined 9,943 students in grades 7, 8 and 9 on measures of eating behaviors and childhood abuse. Physical abuse was examined through the question “Have you ever been physically abused by an adult?” They discovered that students who were physically abused as children were three times more probable to engross in

vomiting, diet pill use, laxative use and diuretic use in comparison to students who did not report this history of abuse.

Ackard, Neumark-Sztainer, Hannan, French, & Story (2001) lead a nation-wide study on 6728 adolescents, and assessed connections among bingeing, purging, and sexual and physical abuse. Physical abuse was examined with the question “Have you ever been physically abused?” trailed by 5 extra questions addressing the location, the perpetrator, and the frequency of the abuse, as well as any discussion of abuse. Adolescents who reported being both physically and sexually abused engaged in bingeing and purging behavior more so than those without this abuse history (35.7% of the girls and 40.7% of the boys who were physically abused reported bingeing and purging).

On the contrary, a more current study by Fischer, Stojek and Hartzell (2010) did not find a connection amongst Childhood Physical Abuse and eating disorder psychopathology in a sample of 489 undergraduate women. Distinct from preceding research conducted on non-clinical samples, this study examined Childhood Physical Abuse utilizing a well-known and trustworthy measure of childhood trauma, the Childhood Trauma Questionnaire by Bernstein and Fink (1998). These researchers also examined eating disorder symptoms utilizing the Eating Disorder Examination Questionnaire by Fairburn and Beglin (1994).

There are a few studies that have assessed the relationship amongst Childhood Physical Abuse and eating disorder symptoms in clinical samples. Furthermore, most of these studies have not discovered considerable connections between these variables (Wonderlich et al., 2007; Kong & Bernstein, 2009). For example, Wonderlich et al. (2007) did not find a connection among Childhood Physical Abuse and eating disorder psychopathology in a sample of women with bulimia nervosa. Likewise, the results of Kong and Bernstein (2009) demonstrated that

Childhood Physical Abuse was not a meaningful predictor of eating disorder psychopathology in a sample of 73 Korean patients with eating disorders.

In general, a history of Childhood Physical Abuse seems to effect the presentation of eating disorder behaviors in non-clinical populations. Nevertheless, as mentioned before very little research exists in regards to the linkage among Childhood Physical Abuse and eating disorder symptoms in non-clinical and even less in clinical populations. Moreover, the definition of Childhood Physical Abuse and measures utilized to examine Childhood Physical Abuse change from study to study. It would be helpful to further conduct research assessing the connection among Childhood Physical Abuse and eating disorder symptoms, utilizing a population of eating disorder patients and an endorsed definition and measure of Childhood Physical Abuse.

Childhood Emotional Abuse and Eating Disorders

Childhood Emotional Abuse has just gained more attention in the eating disorder literature. As previously stated, this sort of abuse is described as child verbal abuse, for example having been yelled at, criticized and humiliated, threatened, controlled, ignored and scapegoated (Fink et al., 1993). Numerous researchers have discovered Childhood Emotional Abuse to be more predominant and more destructive in the long run than other sorts of child abuse (Kent & Waller, 2000; Kent, Waller & Dagnan, 1999; O'Hagan, 1993).

A research study enlightening the high occurrence of Childhood Emotional Abuse was led by Rorty, Yager & Rossotto (1995). These researchers discovered that 76% of those diagnosed with bulimia nervosa as opposed to only 37.5% of a control group reported Childhood Emotional Abuse. Nonetheless, dearth of stable measurement of Childhood Emotional Abuse

averts reliable and equivalent estimates of the occurrence across studies (Kent & Waller, 2000).

Childhood Emotional Abuse and Eating Disorder Symptoms in Non-Clinical and Clinical Populations

Even though studies in regards to Childhood Emotional Abuse and eating disorders is restricted, some research implies that Childhood Emotional Abuse may be a more compelling risk aspect for eating psychopathology than other sorts of childhood abuse (Kennedy, Ip, Samra & Gorzalka, 2007; Wonderlich et al., 2007; Kent & Waller, 2000; Rorty, Yager & Rossotto, 1994).

Kent, Waller & Dagnan (1999) evaluated a non-clinical sample of 236 women on measures of eating psychopathology and childhood abuse (childhood physical, sexual and emotional abuse and neglect). The EDI was utilized to measure eating psychopathology and the Child Abuse and Trauma Scale (CATS) was utilized to evaluate childhood abuse.

The CATS evaluated Childhood Emotional Abuse utilizing a subscale with 7 Childhood Emotional Abuse specific questions. Childhood Emotional Abuse was described as parental behaviors alleged by the victim as being “ridiculing, insulting, threatening and blaming, or unpredictable in nature.” Of the sample, those who had undergone Childhood Emotional Abuse were found to have the most extreme eating disorder acts and perspectives; this group of individuals scored considerably higher on the Eating Disorder Inventory total score in comparison to those who had undergone physical abuse, sexual abuse and neglect. This study did control for numerous sorts of abuse, and the results exposed that Childhood Emotional Abuse provoked the most eating psychopathology in the sample. Kent, Waller & Dagnan (1999) deduced that Childhood Emotional Abuse could be an extremely significant predictor of eating

disorder acts and perspectives.

Fischer, Stojek and Hartzell (2010) assessed the effect of trauma on eating disorder symptoms in a sample of 489 undergraduate women. Childhood Emotional Abuse was measured by the Childhood Trauma Questionnaire and was discovered to considerably foresee eating disorder symptoms evaluated by the Eating Disorder Examination Questionnaire. This study controlled for the impact of Childhood Sexual Abuse and Childhood Physical Abuse.

A study led by Wonderlich et al. (2007) measured the influence of childhood abuse (emotional, physical, sexual abuse and physical neglect) on eating disorder acts in 123 women diagnosed with bulimia nervosa. This study was exclusive in that it utilized two really diverse measures to evaluate eating disorder acts, the Eating Disorder Examination interview (EDE; a measure of eating disorder behaviors and attitudes) and the Ecological Momentary Assessment (EMA; a portable new measure that allows participants to record their day-to-day moods and eating disorder behaviors using palmtop computers). Childhood Emotional Abuse was evaluated utilizing the Childhood Trauma Interview by Fink et al. (1993), and was scored on a 7 point scale for occurrence and severity of abuse. The findings of this study showed that individuals with a history of Childhood Emotional Abuse had the utmost eating disorder psychopathology, as specified by their global score on the EDE. This was true when other effects of abuse were controlled for and when Childhood Emotional Abuse was evaluated separately. Nevertheless, the EMA discovered that sexual abuse was linked with the highest occurrence of purging.

What's more, the relationship among eating disorder symptoms and Childhood Emotional Abuse has been proposed to be accompanied a negative view of self. Additionally, Childhood Emotional Abuse has been related with a lower self-esteem in comparison to other sorts of childhood trauma. Mullen, Martin, Anderson et al. (1996) assessed the long-term effects

of Childhood Emotional Abuse in a community sample of 610 women. The findings suppose that more individuals with a history of Childhood Emotional Abuse reported low self-esteem versus to those with histories of CSA or CPA (37.7% vs. 34%, 35.9%). Gross & Keller (1992) had alike results.

Kent and Waller (2000) state that “emotional abuse is more insidious and difficult to attribute externally than physical abuse or sexual abuse and that this may have a particularly significant impact on self-esteem and thus eating disorder psychopathology” (Kent & Waller, 2000, p.84). Moreover, they state that Childhood Emotional Abuse, different from Childhood Sexual Abuse and Childhood Physical Abuse, might be linked to both bulimic and anorexic syndromes rather than mainly bulimic conditions (Kent & Waller, 2000).

Overall, the treacherous and imprecise nature of Childhood Emotional Abuse has presented restrictions on the assessment of Childhood Emotional Abuse and eating disorder symptoms. The research to-now strongly implies that Childhood Emotional Abuse provokes low levels of self-esteem and high eating disorder psychopathology in both clinical and non-clinical populations, nevertheless the scarce studies that have assessed Childhood Emotional Abuse and eating disorder symptoms have utilized diverse descriptions of abuse and trauma examination measures. It is therefore of significance to additionally assess the effect of Childhood Emotional Abuse in a clinical population, and confirm whether Childhood Emotional Abuse is mainly linked with eating disorder symptoms.

Childhood Emotional and Physical Neglect and Eating Disorders

Childhood Emotional Neglect and Childhood Physical Neglect have gained minimum responsiveness in the literature. Merely a few of studies have assessed the impact of neglect on

eating disorder symptoms (Kong & Bernstein, 2009; Wonderlich et al., 2007; Mitchell & Mazzeo, 2005; Johnson et al., 2002; Hartt & Waller, 2002). Childhood Emotional Neglect is defined as neglecting a child's emotional needs, for example by suppressing love, and failing to inspire growth and learning. Childhood Physical Neglect is defined as incidents in which a child's physical needs are neglected, for instance through the lack of food, clothing and medical care or a deprivation of supervision. Preceding studies have associated childhood physical neglect with eating disorder symptoms (Kong & Bernstein, 2009; Johnson et al., 2002; Mitchell and Mazzeo, 2005) nonetheless no research to-now has discovered a link among childhood emotional neglect and eating disorder symptoms.

The function of Childhood Physical Neglect on eating disorder symptoms has been assessed in two non-clinical studies. The first of the two studies was led by Johnson et al. (2002) and assessed problems with eating and weight in a sample of 782 mothers and their offspring. Partakers were followed for a total of 18 years. These researchers discovered that Childhood Physical Neglect foretold persistent variations in weight, severe dieting and self-induced vomiting (bulimic symptoms) in their sample. Likewise, Mitchell and Mazzeo (2005) assessed the relationship amongst childhood trauma and disordered eating in a sample of 168 male undergraduate students. These researchers discovered that Childhood Physical Neglect was considerably linked with the occurrence of bulimic symptoms.

Three clinical studies have assessed the function of childhood neglect and eating disorder symptoms. Kong and Bernstein (2009) examined the function of childhood trauma on eating disorder psychopathology in a sample of 73 female Korean patients with Bulimia Nervosa. These researchers found that Childhood Physical Neglect was a significant predictor of eating disorder symptoms, however this was not true for Childhood Emotional Neglect. Another clinical study

conducted by Hartt and Waller (2002) examined the role of childhood neglect on bulimic symptoms in a sample of 23 women with Bulimia Nervosa. The results showed that childhood neglect was not related with bulimic pathology. These two studies failed to utilize a large sample size that could have affected their results. Nevertheless, Wonderlich et al. (2007) also did not find an association amongst Childhood Physical Neglect and Childhood Emotional Neglect and eating disorder symptoms in a bigger sample of 123 women with Bulimia Nervosa.

The limited research on childhood neglect seems to be mixed. More research is required to clarify the association amongst this sort of trauma and eating disorder symptoms. Furthermore, since preceding research in this subject is limited it may be valuable to draw from theories allied to other sorts of trauma in order to reveal the clinical aspects related with childhood neglect. It is probable that the primary emotional element of Childhood Physical Neglect and Childhood Emotional Neglect might lead to a comparable clinical presentation in individuals with eating disorders. Likewise, the common physical element in Childhood Physical Neglect and Childhood Emotional Neglect could specify the probability of shared clinical aspects in individuals with these sorts of trauma histories.

Chapter 3

Project Audience and Application Features

Introduction

Preceding general research, in Chapter 2, on the child abuse trauma issues influencing eating disorders, convincingly specifies the necessity for consciousness on these issues and the influence they have on children, youth and adults. This research emphasizes the necessity for information and training amongst marriage and family therapists, psychologists and other professionals in the helping profession, mainly for MFTs' graduate curricular and training programs.

This project's attempt to increase knowledge aspires to help these professionals who are at the forefront of the field, who offer support to patients, precisely to those with childhood trauma and therefore at risk of self-harm behaviors such as eating disorders. Augmenting the consciousness on child abuse issues among graduate students in the MFTs and psychology curricular and training programs will also let these professionals differentiate and recognize the threat that a non-supportive counselor or environment entails for their patients. Knowledge on the part of the professionals will also aid further their patients' access to support and psychotherapeutic treatment and timely approach conveyed behaviors, psychological symptoms and suicide attempts that sway their patients. Moreover, this knowledge will assist to comprehend novel issues and possible corresponding harmful behaviors.

Development of Project

In the fall of 2011, as part of my final MFT requirements, I had to develop a thesis project and fortunately the topic came easy. I wanted a topic I was not only passionate about but could relate to. Practicum A and B had an immense influence in my decision. Professor Rubalcava brought immense awareness of the past influencing current behaviors. I learned that Psychodynamic Counseling places more prominence on the impact of past experience on the development of present behavior, arbitrated in part via unconscious processes. Psychodynamic theory is guided by Object Relations Theory; that is, by the belief that preceding relationships leave enduring traces which disturb self-esteem and can ensue in maladaptive forms of behavior. Within the course we were all able to disclose our deepest issues most of which were related to past experiences, Rubalcava was able to make interpretations about our words and behaviors and soon after we were able to do the same among each other. Consequently, I decided to bring awareness to others in the program and in the field of the distressful struggle I had for years.

In addition to my research analysis, my personal experience with an eating disorder increased my yearning to develop a visual presentation aimed at increasing consciousness of childhood trauma and its influence on the development of eating disorders. Early verbal, emotional and psychological abuse from my father lead to the development of my eating disorder, bulimia. These behaviors were an essential survival mechanism. My eating disorder was a meaningful guide for improvement and learning in all aspects of my life. These behaviors were also an attempt to deal with my feelings in relation to the abuse.

I learned not to blame myself and realized I cannot change the past, I was able to move onward and worked on mending my trauma, I finally gained a sense of personal control and learned to appreciate and love my body again. Therefore, my project will not only help those

with similar struggles but those who want to educate themselves or others on the topic.

Intended Audience

This project, which entails a Power Point presentation (Appendix A) and a Resource/Referral list (Appendix B), which will be made available to faculty and graduate students enrolled in the area of marriage and family therapy, in the Michael D. Eisner College of Education at California State University, Northridge. The Power Point presentation will be of open and free entrée to faculty and graduate students via a webpage (<http://web.ebscohost.com.libproxy.csun.edu>) and can be presented by faculty to students. Moreover, this webpage will comprise referrals and support associations in the area of child abuse in connection to eating disorders and psychotherapeutic treatment. This project might also be of usage to professionals in the field (e.g. marriage and family therapists, clinical psychologists, school psychologists and school counselors) as a service in preventing child abuse.

Personal Qualifications

Professionals and students utilizing this project are faculty and graduate students in marriage and family therapy. Furthermore, this project will be significant to marriage and family therapists, who work with children experiencing trauma or adults who have encountered child abuse and are battling eating disorders. The project's visual presentation might also provide knowledge to teachers and other school professionals on child abuse issues.

Environment and Equipment

In retrieving and using this project a computer and Internet access will be required.

Multimedia projector and printer will be needed if the project is to be utilized as a lecture.

Information from the Power Point, Referral and Resources list will need to be in printed forms handouts and given to students by faculty.

Project Outline

There are 147 slides in this project's Power Point presentation (Appendix A) reinforced by written notes that extensity on each slide's subject. Appendix B offers a list of links for child abuse assessment tools in addition to a link for questionnaire (EAT-26) to be self-administrated by professionals to assess patients' eating disorders. Finally, a pre-post test is offered on (Appendix C) to screen the belief, attitudes and opinions about child trauma, eating disorders or both.

Power Point Slides Outline

Title slide	# 1
Introduction	# 2-7
Significance	# 8-11
Purpose of project	# 12
Definitions of terms	# 13-15
Literature Review	# 16-51
Classification of eating disorders (definitions and diagnosis)	# 16-20
Epidemiology	# 21-26

Comorbidity and Mortality	# 27-31
Historical Context	# 32-48
Culture, Ethnicity, and Eating Disorders	# 49-51
Classification of Childhood Trauma	# 51-58
Childhood Trauma in Eating Disorders	# 59-64
Childhood Sexual Abuse and Eating Disorders	# 65-71
CSA and Eating Disorder Symptoms in Non-Clinical Populations	# 72-76
CSA and Eating Disorder Symptoms in Clinical Populations	# 78-98
Childhood Physical Abuse (CPA) and Eating Disorders	# 99-101
CPA and Eating Disorder Symptoms in Non-Clinical and Clinical Populations	# 102-109
Childhood Emotional Abuse (CEA) and Eating Disorders	# 110-111
Childhood Emotional Abuse and Eating Disorder Symptoms in Non-Clinical and Clinical Populations	# 112-122
Childhood Emotional and Physical (CEN) Neglect and Eating Disorders	# 123-130
Closing Thoughts	# 131-134
Support Resources	# 135-136
References	# 137-147

Chapter 4

Conclusion

Summary

There is an interest among psychologists and other professionals, predominantly school counselors and MFT's in wanting to learn about the relationship between trauma and Eating Disorders. It is estimated that 8 million Americans have an eating disorder, seven million women and one million men. Moreover, one in 200 American women suffer from Anorexia Nervosa. Two to three in 100 American women undergo Bulimia Nervosa. Nearly half of all Americans personally know someone with an eating disorder. A projected 10-15% of people with anorexia or bulimia are males. Furthermore, Eating disorders have the greatest mortality rate of any mental illness. A research study by the National Association of Anorexia Nervosa and Associated Disorders reported that 5-10% of anorexics die within 10 years after contracting the disease; 18-20% of anorexics will be dead after 20 years and only 30-40% ever fully recover. Lastly, the mortality percentage related with Anorexia Nervosa is 12 times higher than the death degree of all causes of death for females 15-24 years old, 20% of people undergoing anorexia will precipitately die from difficulties related to their eating disorder, comprising suicide and heart problems <http://www.state.sc.us/dmh/anorexia/statistics.htm>. This demographic is the basis for a problematic dynamic ascending from the clash between the ignorance of the impact of trauma and lack of treatment.

The resulting linkage plays out for adolescences, which is portrayed by in-group/out-group dynamics, a youth's emerging identity and an average rejection of what is "attractive" based in negative cultural stereotypes. Anorexia is the 3rd most common lingering disease

among adolescents; 95% of those who have eating disorders are between the ages of 12 and 25, 50% of girls between the ages of 11 and 13 see themselves as overweight and 80% of 13-year-olds have attempted to lose weight. Invariably the media adds to the already compound perception of thinness and confusing issues surrounding identity development in adolescence. These intricacies oftentimes end in problematic or conflictive relations between youth that hampers social adaptation and foster self-destructive behaviors.

As formerly mentioned a greater number of studies utilizing adult and child samples, imply that a history of child abuse is associated with disturbances in eating. However, given the samples provided some research has not been able to find a relationship among sexual abuse and eating disorders. Nonetheless, the same research revealed a connection among other forms of maltreatment and eating disorders implying that childhood trauma, in general, might be linked with eating disturbances. Furthermore, more literature concluded that childhood sexual abuse seems to be a considerable risk factor for Bulimia Nervosa, specifically when there are increased degrees of psychotic comorbidity is present.

Therefore, there is a need to increase educational knowledge between professionals. Essential to expand school professionals' support provided to their students is the need to give school counselors, school psychologists, counselors, and teachers the educational tools to improve their understanding of eating disorders, trauma and possible relationship among the two.

Evaluation

To evaluate this project the presenter/educator/user would run a pretest questionnaire (Appendix C) before the presentation of the visual demonstration, in order to screen the belief, attitudes and opinions about child trauma, eating disorders or both. Once the partakers have been disclosed to the material of this project's visual presentation (Appendix A), a posttest

questionnaire (Appendix C) will be given. These questionnaires will incorporate written unambiguous close-ended questions to be a purposive expediency sample. This non-scientific however advantageous comparison will assist the presenter/educator/user in the determination of descriptive statistics to compare the impacts the lecture has on the partakers' beliefs, attitudes and opinions on child trauma, eating disorders or both, their need to know this information and the importance dispensed to the information in place of their work with clients.

The information offered on issues of childhood trauma and eating disorders and the pretest and posttest questionnaires are part of this project's effort to build knowledge between present and future MFT's.

Discussion

My work with different populations, who oftentimes are trauma survivors encompassed but not restricted to domestic violence, early sexual, physical, verbal and emotional abuse, has taught me that these survivors, typically those who underwent trauma at a very early age, are more susceptible to the damaging consequences of environmental stressors. Therefore, they engage in self-harmful behavior such as eating disorders.

This project's curriculum attempts to augment the knowledge of childhood trauma and the relationship with eating disorders. Although the effects of childhood trauma are generalized in this project, there is a necessity for additional research to study the influence of these issues particularly in males, whose demographics seem to be lower due to societal norms and thus lack of reports.

Further references would also include utilizing parent-teacher conferences and/or conversational seminars as formulas to enlarge consciousness on childhood trauma and eating

disorders and seek family support and intervention. Additional research might pursue the inferences and effects and how support from family influences self-image, youth socialization and identity development. The student's parental historical/cultural background, family dynamics, tolerance and social contact are relevant factors for future research as well.

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Appendix A

CHILDHOOD TRAUMA AND INFLUENCE ON EATING DISORDERS

CALIFORNIA STATE UNIVERSITY, NORTHRIDGE

A graduate project submitted in partial completion of the
requirements for the degree of Master of Science in Marriage and
Family Therapy

By
Pamela Bustamante

Introduction

- Eating disorders are abrasive and incapacitating psychiatric disorders, expressed by disturbances in eating behavior and body image.
- Anorexia nervosa (AN) and bulimia nervosa (BN) are the two main types of eating disorders.
- The main characteristics of both disorders incorporate a persistent quest of thinness, an over worry with body weight, shape and size and a distorted discernment of one's own body.
- Eating disorder not otherwise specified (EDNOS) is a diagnostic category provided by the DSM-IV to code individuals who meet some but not all the criteria for anorexia nervosa or bulimia nervosa.

Introduction

- People with anorexia nervosa, bulimia nervosa and eating disorder not otherwise specified engross in an extensive arrange of eating disordered actions mainly to regulate food intake and control body weight.
- A lot of these behaviors may also work as coping methods, which aid to regulate troubled feelings and thoughts.
- Examples of eating disordered behaviors comprise binge eating, self-induced vomiting, restricting food, over-exercising and the misuse of laxatives/diuretics, all of which are employed in varying patterns and combinations.

Introduction

- A history of childhood trauma, specifically sexual (CSA), physical (CPA) and emotional abuse (CEA) and neglect, is usual in this population.
- Individuals with anorexia nervosa, bulimia nervosa and eating disorder not otherwise specified that claim childhood trauma often engross in self- destructive behaviors (Nagata, Kiriike, Iketani, Kawarada, & Tanaka, 1999; Costorphine et al., 2007).
- Research advocates that eating disordered acts and self-destructive acts may be utilized to deal with the thoughts and emotions related with past trauma (Briere and Scott, 2007; Fullerton, Wonderlich, & Gosnell, 1995).

Introduction

- People with eating disorders usually have comorbid psychiatric disorders such as anxiety, depression and substance use disorders (Hudson, Hiripi, Pope & Kessler, 2007; Dansky, Brewerton, Kilpatrick, 2000).
- Psychiatric comorbidity has been discovered to be high in those with eating disorders who report trauma histories (Kong & Bernstein, 2009; Carter, Bewell, Blackmore & Woodside, 2006; Anderson, LaPorte, Brandt & Crawford, 1997).

Introduction

- It is of clinical significance to define whether a history of childhood trauma influences the appearance of eating disorder symptoms and overall psychopathology in individuals with eating disorders.
- The content of this project literature review incorporates research on how eating disorders can be described and classified, the risk factors and dangers of developing eating disorders, how views of the body image have altered over the course of time, as well as perceiving eating disorders in light of cultural aspects.

Introduction

- In this chapter, the clinical features related with AN, BN and EDNOS will be revised, in addition to the epidemiology of these three disorders. Subsequently, clinical characteristics linked with childhood sexual, physical and emotional abuse as well as childhood emotional and physical neglect will be examined. Finally, the literature concerning the association of eating disorders and childhood trauma will be presented.

Significance

- This project addresses the necessity for consciousness, illustrated by Marriage and Family therapists, on matters of trauma and eating disorders. The implied hypothesis is that childhood abuse is associated with eating disorders. Under the implied hypothesis this project generates and arranges an illustration of issues for the expansion of consciousness in regards to eating disturbances and the negative influence of child abuse. Therefore, it is vital to address how to inquire support and treatment as a solution to the negative consequences that childhood trauma has on eating disorder clients.

Significance

- The project is deliberated as an educational mediation to educate about the implied hypothesis. The objective of this project is to generate an educational Power Point presentation to augment the consciousness among graduate students in the field of marriage and family therapy and other professionals of childhood trauma and its association to eating disorders. This increased consciousness intends to progress the professional's receptiveness for early assessment and mediation, to enable clients with childhood trauma access to suitable aid, treatment and resources.

Significance

- Lessening the waiting time that childhood abuse victims may seek to access treatment and support resources donate to reduced possible chances of trauma, intrapsychic struggle and thus eating disorders. The predictable positive outcomes of early intervention may donate to client's perspectives. Therapy will help them understand that these behaviors were an essential survival mechanism until they were able to live in a more optimistic and emotionally vigorous manner.

Significance

- Patient will acknowledge that their eating disorder was a definite gift for progress and learning in all facets of life. Likewise, comprehend that these behaviors were an effort to deal with their emotions relating to abuse or to purify the body of feelings of repugnance. Overall, they will learn not to criticize and know they cannot alter the past, but instead can vigorously decide to move onward and work to mend from their trauma, retrieving a sense of personal control and learn to cherish and love their body again.

Purpose of the Project

- The purpose of this project is to scheme and apply a Power-Point presentation to be made available in a webpage (<http://web.ebscohost.com.libproxy.csun.edu>). The Internet website can be accessed primarily by California State University Northridge (CSUN) MFT, school psychologist, school counselor, clinical psychology graduate students and staff. The website's educational curriculum sections will grant school professionals and students a research based presentation including the areas of: early trauma and eating disorders, child abuse, moreover; diagnosis, co-morbidity, morality rates, epidemiology, historical context, and cultural factors of eating disorders.

Definition of Terms

- Eating Disorders (EDs):
- *Anorexia Nervosa (AN) (Binge-Purge type):* According to the DSM-IV-TR (2000) Anorexia Nervosa of the Binge-Eating/Purging type consists of an individual regularly engaging in binge-eating or purging (i.e. self induced vomiting or the misuse of laxatives, diuretics or enemas) during a current episode of Anorexia Nervosa.
- *Bulimia Nervosa (BN) (Purging Type):* When an individual regularly engages in self-induced vomiting or the misuse of laxatives, diuretics, or enemas during a current episode of Bulimia Nervosa (DSM-IV-TR, 2000).
- *Bulimia Nervosa (Nonpurging Type):* Occurs during a current episode of Bulimia Nervosa when an individual has used other inappropriate compensatory behaviors, such as fasting or exercise, but has not regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas (DSM-IV-TR, 2000).

Definition of Terms

- Childhood Abuse (CA):
- *Childhood Physical Abuse (CPA):* A physical assault or physical boundary violation involving physical contact leading to an intentional and identifiable physical injury and/or intimidation of the victim in a person under the age of 18 (Root and Fallon, 1988).
- *Childhood Sexual Abuse (CSA):* non-contact incidents such as making the victim watch pornography, sexual comments or coercions directed at the victim, and watching the victim get dressed or using the bathroom, as well as interactive experiences such as touching the victim in a sexual way, making the victim touch the perpetrator in a sexualized way, molesting and rape.
- *Childhood Emotional Abuse (CEA):* verbal abuse, for instance having been screamed at, critiqued and chastened, threatened, controlled, disregarded and blamed.

Definition of Terms

- Childhood Abuse (CA) cont:
- Childhood Emotional Neglect (CEN): neglecting a child's emotional needs, for example by suppressing love, and failing to inspire growth and learning.
- Childhood Physical Neglect (CPN): incidents in which a child's physical needs are neglected, for instance through the lack of food, clothing and medical care or a deprivation of supervision.

Literature Review

- **Classification of Eating Disorders**
- **Definitions and Diagnosis**
- The most current version of the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition, text revision, (American Psychological Association, 2000) categorizes Eating Disorders (EDs) into three subtypes: Anorexia Nervosa, Bulimia Nervosa, and Eating Disorder Not Otherwise Specified. EDs are described by severe disturbances in eating behavior (APA, 2000).
- Dieting is characterized as the habit of consuming food in a controlled fashion to attain or preserve a regulated weight (Wikipedia, 2009). EDs differentiate from dieting in that they are sterner in time and intensity and typically cross a line of what is thought as healthy and rational. Nevertheless, facts have demonstrated that dieting behavior augments the chance for EDs (Nielsen, 2001) and numerous cases of eating disorders are led by dieting (Fedoroff &McFarlane, 1998).

Literature Review

- Both AN and BN differentiate from dieting in that they comprise a troubled perception of body weight and shape. AN is characterized by: 1) a refusal to maintain a minimally normal body weight, 2) intense fear of gaining weight or becoming fat, even though underweight, 3) a disturbance in perception of one's own body, and 4) the absence of at least three consecutive menstrual cycles in postmenarcheal females (amenorrhea).
- The DSM-IV-TR (2000) moreover categorizes AN into Restricting types and Binge-Eating/Purging types. The dissimilarity among AN Restricting and Binge-Purge types is the existence or absence of constant binge-eating and purging throughout a present anorexic state.

Literature Review

- BN is described by recurrent episodes of binge-eating followed by inappropriate compensatory behaviors such as self-induced vomiting; misuse of laxatives, diuretics, or other medications; fasting; or excessive exercise, at least twice a week for three months. During a binge episode, an objectively large amount of food is consumed and the eater feels out of control of the eating behavior.
- The DSM-IV-TR (2000) also subdivides BN into Purging and Non-purging types. An Eating Disorder Not Otherwise Specified refers to any disorder of eating that does not meet criteria for either of the preceding two specific Eating Disorders or their subtypes.

Literature Review

- Recent reports evoke that in the approaching DSM-V, ED categories will be more detailed and accurate (DeAngelis, 2009). An example is the recent prerequisite for amenorrhea in order to be diagnosed as AN. While this categorization is beneficial for a particular subset of women with Anorexia, it does not account for men, women on birth control, or women with AN who do not miss their periods (DeAngelis, 2009), making it more problematic to reach at a diagnosis of Anorexia in particular populations.
- Current reports from the Eating Disorders Work Group developing the novel DSM-V criteria propose that binge-eating disorder will be implemented as a diverse category (DeAngelis, 2009). Additional developments might also encompass how to justify for cultural variables with EDs, how to diagnose children with EDs, and more exact descriptions of words such as "binge" (DeAngelis, 2009).

Literature Review

- The clinical characteristics of AN comprise perfectionism, social anxiety, rigidity, over activity, obsessiveness, and the need for control fluctuating with episodes of impulsiveness (Wilson, Becker, Heffernan, 2003).
- The clinical factors of BN are parallel to those of AN, such as feelings of intense guilt, shame, and severity of thinking. Even though dissimilarities occur among AN and BN, such as those with BN predominately being in the average weight range and less resilient to treatment than those with AN (Wilson et al., 2003), there are more parallels than dissimilarities.

Literature Review

- **Epidemiology**
- The onset for AN typically happens in adolescence between the ages of 14-18 (Wilson et al., 2003).
- With BN, the onset has a broader array, from adolescence to early adulthood.
- The occurrence rates differentiate to some extent among comprehensive research, they are usually stable. In the United States the occurrence rates for females with AN have been found to be between 0.2 to 0.5 % (Nielsen, 2001; Wilson et al., 2003). The occurrence rates for BN are a bit more, between 1-2% in females and 0.1% in males (Nielsen, 2001; Wilson et al., 2003).

Literature Review

- **Epidemiology**
- The occurrence rates for BN are a bit more, between 1-2% in females and 0.1% in males (Nielsen, 2001; Wilson et al., 2003).
- Samples from France obtained occurrence rates for BN to be comparable to those in the United States; 1.1% in women and 0.2% in men (Nielsen, 2001).
- Norwegian areas conveyed occurrence rates of 0.4 % for AN and BN rates of 1.1% in females (Nielsen, 2001).

Literature Review

- **Epidemiology**
- It is crucial to remember that the existing occurrence rates for eating disorders are expected to be miscalculated because of both the private nature of the disorders and the great number of individuals who have subclinical onsets for the disorders.
- The prevalence of females with AN was shortly quoted as 8 per 100,000 and 0.5 per 100,000 in males (Nielsen, 2001).
- The prevalence rates of BN were established to be 13 per 100,000 females (Nielsen, 2001).
- In clinical samples 5-10% of eating disorder patients were recognized as male (Wilson et al., 2003).

Literature Review

- **Epidemiology**
- Several of the studies obtained on sexual orientation and eating disorders has been questionable, even though homosexuality in males has been quoted as a greater risk aspect for eating disorders due numerous men's provenance on thinness in the gay culture (Wilson et al., 2003)
- A probable explanation about the emergence of EDs and the discrepancies among genders is the role of socializing males to express their symptoms while females are trained to internalize their symptoms. This can enlighten why both genders underwent physical abuse but males are more liable to carry on the cycle of abuse and become offenders whereas females are more liable to internalize their symptoms and acquire EDs.

Literature Review

- **Epidemiology**
- The proportions of college students with EDs are reasonably greater than the rest of the population.
- Within western cultures 14% of White students, 2.7% of Asian students, and 3-4% in African American students have Bulimia Nervosa (Fedoroff & McFarlane, 1998).
- Latino encompassing around 13% of the college students in the US

Literature Review

- **Epidemiology**
- In comparison to nonwestern societies such as Japan (.005-.04%) and Hong Kong (.46%) the rates of EDs in students was much less (Fedoroff & McFarlane, 1998).
- Eating disorders appear to be rising cross-culturally (Wassenaar, le Grange, Winship et al. 2000; Miller & Pumariega, 2001).

Literature Review

- **Comorbidity and mortality**
- A staggering 97% of inpatient eating disorder clients portrayed more than one comorbid diagnosis (Blinder, Cumella, & Sanathara, 2006).
- Mood disorders, specifically unipolar depression was designated in 94% of the ED patients (Blinder, et al., 2006).
- Anxiety disorders were the second most usual comorbid disorder, found in 56% of the examined population, followed by substance disorders in 22% of the partakers (Blinder, et al., 2006).

Literature Review

- **Comorbidity and mortality**
- BN presented greater rates of alcohol abuse and polysubstance abuse out of all the ED subtypes.
- In binge-purge type AN, Obsessive-Compulsive Disorder, Posttraumatic Stress Disorder and Schizophrenia were twice as probable to co-occur than in other ED categories (Blinder, et al., 2006).
- These outcomes prop exceedingly high degrees of comorbid psychiatric disorders in ED patients.

Literature Review

- **Comorbidity and mortality**
- Research obtained in regards to mortality degrees in eating disorders seems very mutable, even though there is accord in that eating disorders have extremely high mortality degrees when compared with other psychiatric diagnoses (Walsh, Wheat, & Freund, 2000).
- EDs seem to have one of the greater mortality degrees of any psychiatric disorder, for instance the mortality rate due to Anorexia is twelve times greater than the mortality rate for people between 15 and 24 years of age (Sullivan, 1995; Walsh et al., 2000).

Literature Review

- **Comorbidity and mortality**
- Nielson (2001) quotes raw mortality degrees for AN to be at 5.9% (178 deaths per 3,006). Of this 5.9% mortality degree 54% died from eating disorder difficulties, 27% from suicide, and 19% from unidentified or other causes (Nielsen, 2001).
- Additional studies quote AN's mortality degree to be at 10% (Wilson et al., 2003) or as high as 15% (Walsh et al., 2000).
- Mortality degrees for BN are significantly less than AN and there is much complexity directly connecting the cause of death to BN. Raw mortality degrees from BN are from 1-3% (Quadflieg & Fichter, 2003).

Literature Review

- **Comorbidity and mortality**
- In longitudinal research mortality degrees were typically at 2.8% after a two-year follow-up, 2.1% after 4.5 years follow-up, and 2.2% after 10 years follow-up (Quadflieg & Fichter, 2003). BN ranged from .03% (7 deaths per 2,194 people) to 20% (Nielsen, 2001).

Literature Review

- **Historical content**
- Eating Disorders are not a current prodigy and countless types of Eating Disorders can be outlined all through history. In prehistoric eastern religions, spiritually inspired austerity leading to self-starvation similar to Anorexia (Miller & Pumariega, 2001).
- Ancient Christians who were referred to as "Gnostic cults" participated in intense fasting as a response in contradiction to hedonism and materialism (Miller & Pumariega, 2001).

Literature Review

- **Historical content**
- Thru the Middle Ages and the early Renaissance, women utilized spiritually inspired self-starvation to gain sainthood in the Roman Catholic Church (Miller & Pumariega, 2001).
- Rudolph Bell in his book Holy Anorexia (1985) assess the existence of AN between women in the Roman Catholic Church. Bell invented the term "holy anorexic," in reference to women whom displayed the standards that met today's meaning of an eating disorder, but credited the anorexic acts as a means to become more allied to God.

Literature Review

- **Historical content**
- Bell explicates the complex prodigies of "holy anorexia" as part of a bigger battle in contrast to a patriarchal culture. Women who were capable to repel food and water were perceived as being capable to defeat the physical drives of the sin teeming world.
- Bell quotes such saints as "Catherine of Siena, Veronica Giuliani, Mary Magdalen de' Pazzi, and Margaret of Cortona" as women who fit under the grouping of "holy anorexia." Many of the 250 Italian women Bell clarified participated in the anorexic acts as a way of self-punishment.

Literature Review

- **Historical content**
- Even though these illustrations from history have a lot of similarities to the exposition of eating disorders it's vital to remember that these illustrations seem to differentiate on inspirational natures, in that the central incentive of AN is a worry of obesity and irrationality around appearance, on the contrary to starvation as a method to a religious purpose. Nonetheless, it is problematic to ascribe probable psychological incentives as little to no data was chronicled on the historical expositions of eating disorders.

Literature Review

- **Historical content**
- Far along, in the 17th and 18th centuries perceptions on self-starvation altered from "holy" to being "possessed by the devil" and thereafter to perceiving those involved in this behavior as deceptions and physically or mentally sick (Miller & Pumariega, 2001).
- In approximately the 19th century the "tubercular" view became fetishized as dazzling. It was not till the late 19th century that AN was accepted as a medical disorder (Miller & Pumariega, 2001).

Literature Review

- **Historical content**
- The history of BN can be drawn back to ancient Egyptians who engrossed in medically sanctioned purging (Miller & Pumariega, 2001).
- In old Rome customary vomiting was performed by the affluent in "vomitoriums" which were assembled for people to gulp emetics and vomit following eating (Miller & Pumariega, 2001).
- Even though Bulimia has roots dating as far back as old Egypt and Rome it was not classified as a distinct diagnostic unit until 1979 (Miller & Pumariega, 2001).

Literature Review

- **Historical content**
- Are EDs a result of a historical period's social compels? Several from the Feminist view would perceive eating disorders as a "social disease" (Seid, 1994).
- Seid (1994) noted that the female body has not altered, but the idyllic of the female body type has, along with the approaches and determination employed to reach that idyllic.
- An alternate hypothesis is that perfect body types imitate the principles of present society and that as history changes, also do the principals and standards about body types (Derenne & Beresin, 2006).

Literature Review

- **Historical content**
- In the 15th century, gothic cathedrals exhibited extremely thin women in ceiling canvas (Seid, 1994).
- During the 16th century painters in Northern Europe apprehended to painting thinner than normal females in the nude.
- Colonial times in America were stern and thus prized physically sturdy, capable, and fertile women (Derenne & Beresin, 2006).

Literature Review

- **Historical content**
- In the 17th century thinness was not associated to health and strength as it is currently, but with fragility and brittleness (Seid, 1994). It seems that the idealism of skinny waists and slenderness was a luxury for the wealthy at this time period and that, overall, slender women were perceived as ugly.
- Inflatable under-garments were invented and worn by thin women (Seid, 1994).

Literature Review

- **Historical content**
- Throughout the 17th Century the principles were different from today's body type ideals. Fat was related with a "stored up force" for vigor and strength, and represented suitable nature and health.
- There was a change from 1800's to 1900's when thinness came into style (Seid, 1994).

Literature Review

- **Historical content**
- From the 1830s through the 1850s women struggled for the little waist flaunted by Scarlet O'Hara in *Gone with the Wind* (Seid, 1994).
- Seid (1994) suggests that the change can be accredited partially to the Modernists' aesthetic for decreasing things down to their fundamental forms.
- Corsets were the pinnacles of 19th century fashion, where the idyllic of small waists with large breasts continued. It was supposed that flimsiness made women more attractive for marriage (Derenne & Beresin, 2006).

Literature Review

- **Historical content**
- With the commencement of feminism, a boyish, non-curveous skinny trend came into fashion around the 1920's denoted to as "flapper fashion" (Russell & Treasure, 1989; Derenne & Beresin, 2006).
- Soon after, World War II began and with men absent over seas, cherished body types in the United States allied with strong, capable and bright women (Derenne & Beresin, 2006).
- When the men came back from war, the standards soon changed towards customary gender roles, cherishing curveous bodies that represented fertility (Derenne & Beresin, 2006).

Literature Review

- **Historical content**
- With postwar freedom and plenty in the U.S., a dread grew of Americans becoming ethically and physically lenient. A "fat phobia" followed with a worry around fat (animal fat specifically) that lead Americans to become ill and unhealthy (Seid, 1994).
- The 1960's was an era of sexual liberty and struggling for women's rights when the prewar principles of boyish figures became "in" again, feasibly with the body as a symbol for parity (Derenne & Beresin, 2006).

Literature Review

- **Historical content**
- By the 1960's the "standard" body size for women became perceived as overweight (Seid, 1994).
- Seid (1994) related the current approaches concerning food and body shape to Victorian era taboos about sex and contemporary approaches.
- Seid (1994) leaves readers with the query of whether cultures continuously oblige some form of power in order to feel refined.

Literature Review

- **Historical content**
- Presently, women are blasted with varied messages from the media in regards to the perfect body types; the super thin run way model, big breasted supermodels with thin waists, and fit and sturdy athletes.
- A prevalent lay perspective of eating disorders faults the media for propagating unrealistic body outlooks.
- In the 1980's the typical fashion model was 8% skinnier than the "normal" woman (Derenne & Beresin, 2006).
- Currently, the typical model is 23% skinnier than the "normal" woman (Derenne & Beresin, 2006).

Literature Review

- **Historical content**
- Additional props for the media's encouragement on body image is the Becker study lead in 1995. Becker et al. (2002) studied ethnic Fijian adolescents pre and post the overview of western television to their country.
- Becker et al. (2002) discovered that extended exposure to television had an adverse influence on eating behaviors and approaches in television guideless teenage girls.
- Previous to the study the percent of teenage dieting was at 0%, after the deluge of television this number ascended to 69% (Becker et al., 2002).

Literature Review

- **Historical content**
- The view that everyone can attain this 'idyllic weight" with sufficient determination has shifted society towards a "censure the victim" stance (Seid, 1994). Fat has become associated with disgrace and griminess, whereas thinness is associated with purity and self-esteem, which leans to fit America's self aid philosophy (Seid, 1994).

Literature Review

- **Culture, Ethnicity, and Eating Disorders**
- The data on culture, ethnicity and eating disorders seems to sustain varied perspectives and a numerous of views.
- Some researchers propose that EDs are a culturally compelled condition, others find that with women of different cultural upbringings, eating disorders imitate a coping mechanism for transitioning to a novel culture (Fedoroff & McFarlane, 1998; Wassenaar, le Grange, & Winship et al., 2000; Miller & Pumariega, 2001; Palmer, 2007).

Literature Review

- **Culture, Ethnicity, and Eating Disorders**
- Additional studies imply that the typecast of eating disorders as a western marvel is a product of the lack of research on a variety of populations and locations (Wassenaar, le Grange, Winship et al. 2000).
- The influence of culture on EDs can be associated via examinations on Western versus Eastern countries. One study contrasting Western countries (United States and France) to Eastern countries (India and Tibet) revealed no substantial dissimilarity in eating pathology when all aspects were controlled (Rubin, Gluck, & Knoll, et al, 2008).

Literature Review

- **Culture, Ethnicity, and Eating Disorders**
- In Rubin et al.'s study (2008), girls from The United States had less body image inconsistencies than Tibetan girls. Tibetan girls had the greatest body image inconsistencies, desiring to be bigger than their actual body size.
- It is probable that the upsurge in body image inconsistencies is due to the linkage among social class and upbringing.

Classification of Childhood Trauma

- Numerous children bear disturbing behaviors of maltreatment that have extensive consequences on their physical and psychological well-being.
- Childhood sexual, physical, emotional abuse, and childhood neglect are all types of child maltreatment (Mash & Wolfe, 2005).
- The occurrence rate of child maltreatment in Canada is 9.7 cases per 1000 children (Trocme & Wolfe, 2001).

Classification of Childhood Trauma

- The DSM-IV-TR has dedicated a small segment of the Axis I category “Other conditions that may be a focus of clinical attention,” to childhood sexual and physical abuse and childhood neglect (APA, 2000).
- Nevertheless, sexual, physical and emotional abuse, and childhood neglect are all generally reported in clinical sites.

Classification of Childhood Trauma

- Child trauma has been described in diverse ways throughout the literature because of the absence of accord over how aspects such as age and severity of trauma out to be included into definitions of trauma.
- The Childhood Trauma Interview by Fink, Bernstein, Foote, Lovejoy, Ruggiero, & Handelsman (1993) is generally utilized at clinical sites to evaluate numerous types of childhood trauma.
- The descriptions of trauma utilized for the Childhood Trauma Interview were based on a detailed review of the childhood trauma literature.

Classification of Childhood Trauma

- Fink et al. (1993) defined six types of childhood trauma, four of which relate to this study: 1) sexual abuse, 2) physical abuse, 3) emotional abuse and 4) physical neglect.
- Childhood sexual abuse was defined as non-contact incidents such as making the victim watch pornography, sexual comments or coercions directed at the victim, and watching the victim get dressed or using the bathroom, as well as interactive experiences such as touching the victim in a sexual way, making the victim touch the perpetrator in a sexualized way, molesting and rape (Fink et al., 1993).

Classification of Childhood Trauma

- Fink et al. (1993) described CPA as incidents, in which the child is hit, beaten, kicked, tossed against walls, locked in closets, burned, strangled, and cut.
- CEA is described as verbal abuse, for instance having been screamed at, critiqued and chastened, threatened, controlled, disregarded and blamed.
- Physical neglect is described as incidents in which the victim was unsupervised by the perpetrator, and denied of food, clothing and medical care (Fink et al., 1993).

Classification of Childhood Trauma

- The Childhood Trauma Questionnaire (CTQ, Bernstein & Fink, 1998), a self-report tool of childhood trauma resulted from the Childhood Trauma Interview, describes a history of childhood emotional neglect utilizing these five element on the self-report measure: “1) there was someone in my family who made me feel important or special, 2) I felt loved, 3) people in my family looked out for each other, 4) people in my family felt close to each other and 5) my family was a source of strength and support.”

Classification of Childhood Trauma

- The creators of the CTQ assert that minute ratifications of these five elements are related with childhood emotional neglect (Bernstein & Fink, 1998).
- These five sorts of childhood trauma are related with numerous psychiatric troubles such as the development of anxiety and depression, complexities in sexual adjustment, criminal and antisocial acts as well as eating disorders (Mash & Wolfe, 2005).

Childhood Trauma AND Eating Disorders

- People with EDs frequently report histories of childhood trauma (Rorty, Yager & Rossotto, 1994; Van Gerko, Hughes, Hamill & Waller, 2005; Wonderlich et al., 2007).
- Studies have focused on detecting relationships among eating disorders and reported childhood trauma, mainly sexual, physical and emotional abuse (Anderson, LaPorte & Crawford, 2000; Rorty, Yager & Rossotto, 1995; Fullerton, Wonderlich & Gosnell, 1995; Wonderlich et al., 2007).

Childhood Trauma AND Eating Disorders

- A history of childhood trauma in people with eating disorders has been related with an upsurge in risk taking actions such as alcohol abuse, suicide efforts, self-harm and shoplifting (Fullerton, Wonderlich & Gosnell, 1995; Claes & Vandereyken, 2007).

Childhood Trauma AND Eating Disorders

- There have been different explanations set forth to aid explain why people with a history of childhood trauma would consequently develop an eating disorder or engross in eating disordered acts (Schwartz & Gay, 1996).
- Briere and Scott (2007) state that eating disordered acts are both direct consequence and coping retorts to childhood abuse. An illustration of a direct result of childhood abuse incorporates struggling for an unrealistic body type through dieting or confining food consumption, as a consequence of a destroyed self-esteem and weak body view due to abuse.

Childhood Trauma AND Eating Disorders

- On the other hand, coping retorts are acts utilized to control distress and tautness related with trauma.
- They propose that binge eating and purging help to numb individuals of any adverse emotional feelings or judgments felt as a response of the trauma and therefore serve as coping consequences.

Childhood Trauma AND Eating Disorders

- Furthermore, it has been implied that self-induced vomiting, confining food consumption and laxative misuse can grant forms of bodily regulations for victims of sexual abuse including the lack of control over ones own body (Schwartz & Gay, 1996; Briere & Scott, 2007).
- A lot of weight loss behaviors such as confining and purging might play a part in preventing the emergent of a feminine body to evade forthcoming sexual relationships (Schwartz & Gay, 1996).

Childhood Trauma AND Eating Disorders

- The precise purpose of each type of eating disorder act might differ from individual to individual, but typically the symptoms are perceived as assisting the individual uphold psychological balance.

(CSA) and Eating Disorders

- Incidence studies show that about 30% of individuals with EDs report histories of childhood sexual abuse (CSA), which is parallel to other psychiatric populations (Pope & Hudson, 1992; Connors & Morse, 1993; Steiger & Zanko, 1990; Oppenheimer et al., 1985; Rorty & Yager, 1996).
- Root and Fallon (1988) discovered that 28% of their eating disorder patient population reported a history of CSA.
- Results from incidence studies differ due to the utilization of diverse methods and the variety of descriptions of sexual abuse that remain in the literature.

(CSA) and Eating Disorders

- Presently, the relationship between eating disorders and CSA does not seem to be causal; nonetheless, the literature does propose that this sort of abuse might serve as a non-specific risk feature for psychiatric troubles (Wonderlich, Brewerton, Jolic, Dansky & Abbott, 1997; Wonderlich, Wilsnack, Wilsnack & Harris, 1996).

(CSA) and Eating Disorders

- Various studies have found that a history of CSA is more predominant in bulimic conditions, such as bulimia nervosa or anorexia nervosa binge-purge subtype, in comparison to restrictive conditions such as anorexia nervosa restricting subtype (Carter et al., 2006; Van Gerko et al, 2005; Oliosi & Dalle Grave, 2003; Wonderlich et al., 1997).
- Studies have also associated sexual assault throughout adulthood to BN (Dansky, Brewerton, Kilpatrick & O'Neil, 1997).

(CSA) and Eating Disorders

- Carter, Bewell, Blackmore & Woodside (2006) studied 77 anorexic patients admitted to an eating disorder inpatient clinic. The partakers were tested on measures of eating disorder symptoms and additional psychiatric conflicts as well as childhood sexual abuse histories.
- The results showed that a considerably higher number of inpatients diagnosed with the binge-purge subtype of AN conveyed a history of CSA (65%) in comparison to those diagnosed with the restricting subtype of AN (37%).

(CSA) and Eating Disorders

- Oliosì & Dalle Grave (2003) compared rates of CSA between individuals diagnosed with the purging subtype of AN, the bingeing subtype of AN and the restricting subtype of AN.
- They found that those diagnosed with AN binge subtype (20%) and AN purge subtype (34.2%) reported more CSA in comparison to those diagnosed with AN restricting subtype (7.5%).

(CSA) and Eating Disorders

- A clinical study by Van Gerko et al. (2005) studied histories of CSA and eating disorder acts in women with different eating disorder diagnoses.
- A lower rate of women with anorexia nervosa restricting-subtype (16.1%) reported CSA in comparison to those with bulimia nervosa (30.4%) or anorexia nervosa binge-purge subtype (29.5%).

(CSA) and Eating Disorders

- Moreover, through all diagnostic groups, bulimic acts such as bingeing, vomiting, laxative and diuretic abuse were conveyed more often by those who underwent CSA in comparison to those without this trauma history.
- Consequently, individuals with eating disorders recurrently report histories of CSA. This is particularly accurate of individuals with bulimic syndromes.

CSA and Eating Disorder Symptoms in Non-Clinical Populations

- It has been implied that a history of CSA is related with particular eating disorder symptoms. The studies below emphasize research results on the linkage amongst CSA and eating disorder symptoms in non-clinical populations.
- A study by Wonderlich, Wilsnack, Wilsnack & Harris (1996) evaluated a national sample of 1099 US women on amount of ED behaviors and past trauma. The outcomes from this study disclosed that more women with a history of CSA (19.1%) engrossed in binge eating in comparison to those who did not report CSA (7.8%).

CSA and Eating Disorder Symptoms in Non-Clinical Populations

- Wonderlich et al. (2000) compared eating disturbances in 20 children with histories of CSA to a control group of 20 children who did not report a history of trauma.
- The conclusions designated that purging acts, dieting and weight discontent all happened at a considerably higher degrees in the group of children who had undergone CSA.

CSA and Eating Disorder Symptoms in Non-Clinical Populations

- Ackard and Neumark-Sztainer (2003) evaluated the occurrence of CSA in 81,247 high school students. Those who reported a history of CSA were two times more liable to binge-eat or fast, four times more liable to vomit or utilize diet pills, and five times more liable to utilize laxatives in comparison to the non-abused group of female students.

CSA and Eating Disorder Symptoms in Non-Clinical Populations

- Sanci et al. (2008) evaluated the connection amongst CSA and the later start of eating disorder symptoms in a longitudinal study including 1936 grade 9 female student partakers.
- The students were tracked and evaluated for eating disorder symptoms utilizing the DSM-IV occasionally until they were about 24 or 25 years old.
- CSA was evaluated by asking the partakers whether or not they had ever undergone any unwelcomed sexual experiences engaging an adult or older person before the age of 16.

CSA and Eating Disorder Symptoms in Non-Clinical Populations

- The findings implied that females who reported more than two incidents of CSA were more than four times more liable to acquire purging behavior among the ages of 16 and 17 years old than those with no CSA.
- Females who reported two or more incidents of CSA were more than three times more liable to acquire binge eating behavior among the ages of 16 and 17 years old in comparison to those who did not report CSA.
- These studies demonstrate that CSA is linked with a wide array of eating disorder symptoms in non-clinical populations.

Appendix B

Child abuse assessment resources

<http://www4.parinc.com/Products/Product.aspx?ProductID=CAP>

http://www.childwelfare.gov/systemwide/assessment/family_assess/id_can/

<http://www.cebc4cw.org/assessment-tools/>

Eating Attitudes Test (EAT-26)

<http://www.santarosanutrition.com/files/Download/EAT26Test120105.pdf>

Appendix C

Pretest/posttest

1. Does research support child abuse is associated with disturbances in eating?
2. Are Anorexia nervosa (AN) and bulimia nervosa (BN) the two main types of eating disorders?
3. Do AN and BN share similar characteristics?
4. Is a history of childhood trauma, sexual abuse (CSA), physical abuse (CPA) and emotional abuse (CEA) and neglect found in AN and BN populations?
5. Do AN and BN differentiate from dieting in that they comprise a troubled perception of body weight and shape?
6. Does the onset for AN typically happen in adolescence between the ages of 21-28?
7. Have various studies found that a history of CSA is more predominant in bulimic conditions?
8. Are the occurrence rates for BN are between 1-2% in females and 0.1% in males?
9. In clinical samples is 5-10% of eating disorder patients recognized as male?
10. Are the proportions of college students with EDs reasonably less than the rest of the population?
11. Do eating disorders have extremely low mortality degrees when compared with other psychiatric diagnoses?
12. Is Anorexia twelve times greater than the morality rate for people between 15 and 24 years of age?
13. Are mortality degrees for BN significantly less than AN and is there much complexity directly connecting the cause of death to BN?

14. Are eating disorders a current prodigy?
15. In the 17th century was thinness not associated to health and strength as it is currently, but to fragility and brittleness?
16. By the 1960's did the "standard" body size for women become perceived as overweight?
17. In the 1980's was the typical fashion model 23% skinnier than the “normal” woman?
18. Has child trauma been described in diverse ways throughout the literature?
19. Is the Childhood Trauma Questionnaire a self-report tool of childhood trauma?
20. Do incidence studies show that about 60% of individuals with EDs report histories of CSA?