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Relationship between childhood sexual abuse, weight, and attitudes toward obesity in lesbians

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RELATIONSHIP BETWEEN CHILDHOOD SEXUAL ABUSE, WEIGHT, AND ATTITUDES TOWARD OBESITY IN LESBIANS

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ABSTRACT

In many professional practice settings, it is very likely that social workers will work with female clients who identify as lesbian or bisexual. These sexual minority females are more likely to be overweight or obese, have a history of childhood sexual abuse, and have more positive attitudes toward overweight and obesity than heterosexual women. In this study, the author sought to identify the relationship between childhood sexual abuse, obesity, (specifically, body mass index [BMI]), and attitudes toward obesity among lesbian and bisexual women. Eighty-five sexual minority females completed a survey. Childhood sexual abuse was found to be positively correlated with BMI. However, lesbians' attitudes toward obesity were not associated with childhood sexual abuse nor were they found to be associated with BMI. Additionally, lesbians did not report significantly different attitudes toward BMI based on their own BMI and history of childhood sexual abuse. These findings are further discussed in the context of previous research, limitations, and implications for direct practice.

CHAPTER 1
INTRODUCTION

Obesity, a health condition in which fat tissue has collected to a magnitude that negatively impacts health (Adegboye, 2010), is a well-documented concern in today's society as its prevalence is steadily increasing with an estimated 32.7 percent of United States adults over the age of 20 being overweight, 34.3 percent being classified as obese, and 5.9 percent being classified as extremely obese, according to the results from the 2005-2006 National Health and Nutrition Examination Survey (Centers for Disease Control and Prevention, 2009). Research suggests demographic characteristics such as race and gender affect the probabilities of individuals being obese (Yen et al., 2009). More specifically, obesity is highest among non-Hispanic Black women (about 82 percent) and Hispanic women (about 76 percent) (National Heart, Lung and Blood Institute, 2012). Health care costs in the United States are also rising with an estimated 5.7 percent (approximately $52 billion annually) of direct health care costs are associated with obesity. Such direct health care costs are inclusive of personal health care, physician health care services, allied health care services, medication and prescription services (Wolf & Colditz, 1998).

Obesity is associated with life-threatening health disorders such as hypertension, cardiovascular disease, diabetes mellitus, and even some cancers (Must et al., 1999), as well as psychological conditions including depression, anxiety, suicidal ideation, and disordered eating (Gustafson et al., 2004). More specifically, psychological characteristics of persons who are obese include less optimal food choices and cognitive factors relating to self-regulation and motivation, and increased prevalence of mental illnesses (Karasu, 2012). Furthermore, biological characteristics include the genetic contributions of as much as 65% of what results in the condition of obesity (Rankinen et al., 2006). Even fat distribution has been determined to be

most likely influenced by genetics (Karasu & Karasu, 2010, p. 113) with some fat accumulating around the waist (i.e., "apple-shaped") or around the hips (i.e., "pear-shaped"). Environmental factors associated with obesity include sleep deprivation, disrupted circadian rhythms, "portion distortion" (Wansink, 2004, p. 1103) and lack of knowledge of "consumption norms" relating to portion control (Wansink, 2004, p. 1103), and exposure to medications and viruses (Karasu & Karasu, 2010).

The increasing prevalence of childhood sexual abuse (CSA), defined as any action involving children consisting of sexual activity such as penetration (Feldman & Meyer, 2007), is just as alarming with 68,400 (9.5 percent) out of 720,000 child victims of maltreatment reporting sexual abuse (U.S. Department of Health and Human Services [DHHS], 2010). Research suggests that girls are more frequently victimized than boys, although research does suggest that boys are more often abused than the number of reported cases would indicate (Finkelhor, 1994). Peak vulnerability for abuse of both boys and girls occurs between the ages of 7 and 13 (Finkelhor & Baron, 1986). Prominent risk factors for childhood sexual abuse include those children that belong to a lower social class as well as those children that do not have adequate parental involvement that results in a poor parent-child relationship. Studies suggest that children who have lived for an extended amount of time away from their parents are at high risk for sexual abuse (Finkelhor, 1994). Children with substance using or emotionally unstable parents are also at high risk as well as children who have grown up in an environment where marital conflict occurs (Finkelhor, 1994). Children who have experienced some sort of sexual abuse are at higher risk for depression, suicidal ideation, severe attachment disturbances, and post-traumatic stress disorder (PTSD) among other mental illnesses (Smith et al., 2012). Survivors of childhood sexual abuse also report higher somatization symptoms such as irritable

bowel syndrome, chronic pelvic pain, headaches, back aches, muscle aches, fibromyalgia, joint pain, chest pain, shortness of breath, irregular heart beat and ischemic heart disease (Irish, 2009). Moreover, a secondary data analysis conducted by Smith et al. (2010) on heterosexual and lesbian women enrolled in the ESTHER Project at the University of Pittsburgh between 2003 and 2006 has confirmed a direct relationship between obesity and CSA. The ESTHER Project was a cross-sectional study that identified heart disease risk factors among women living in Pittsburgh, Pennsylvania. Smith et al. stated that individuals who have experienced CSA are more likely to be obese or morbidly obese than individuals who have not experienced CSA.

The issues of obesity as well as sexual abuse affect all segments of the population, including lesbian, gay, bisexual, and transgender (LGBT) individuals. Lesbians, in particular, are at high risk for both CSA and obesity. Smith et al. (2010) states that lesbians have reported significantly higher rates of CSA than heterosexual women. In addition, lesbians have been found to have higher rates of obesity, as compared to those females who are heterosexual, bisexual and transgendered (Roberts et al., 2010). Moreover, a recent review of the obesity literature found lesbians to be significantly more likely to be obese and to be more accepting of it than heterosexual women (Bowen et al., 2008). The prevalence of obesity and previous CSA among lesbians, coupled with recent findings of lesbians' overall acceptance of obesity, may have both physical and psychosocial risks for certain lesbian subpopulations.

Despite the empirical literature that examines these variables separately (obesity, CSA, and attitudes toward obesity), no published reports examine previous CSA, obesity, and attitudes toward obesity among lesbian and bisexual women. This study aims to fill that gap by identifying interrelationships among lesbians' attitudes toward obesity, current weight, and history of childhood sexual abuse.

CHAPTER 2
REVIEW OF LITERATURE

The purpose of this study is to identify any relationships between previous CSA, obesity, and attitudes toward obesity among lesbian and bisexual women. A search of the literature was conducted within the online research databases Psychology and Behavioral Sciences Collection, PsycARTICLES, PsycINFO, and SocINDEX with Full Text using the following terms and phrases: lesbians, obesity, overweight, childhood sexual abuse, mental health, and attitudes. The search yielded 98 hits, 15 of which were included in this review. This chapter discusses obesity, childhood sexual abuse, and attitudes toward weight among the lesbian population.

Theoretical Framework

Lesbians and Obesity. Obesity rates have more than doubled in the United States within recent years with the majority of obese adults now at more than 50 percent of the general population (Yancey et al., 2003). There is a prevailing knowledge that obesity rates among lesbians are far higher than in their heterosexual counterparts (Yancey et al., 2003). One explanation as to why lesbians may be at greater risk for being overweight or obese stems from social stress theory, the stress concept which purports that stressors from the social environment, such as victimization, discrimination, oppression, stigmatization, rejection and vigilance (Fredriksen-Goldsen et al., 2010) can be defined as life-changing and sometimes traumatic events and conditions that require the individual to adapt to these new stressors (Meyer, 2003). For example, those individuals suffering from discrimination related to homophobia must adapt to such stressful events in the environment (Allison, 1998). These events may include being victims of bullying, discrimination at work, or even physical harassment based on one's sexual orientation. These environmental stressors may lead to consequences involving mental and physical illnesses (Meyer, 2003) and therefore may have a significant effect on the socially

stigmatized. Moreover, one component of social stress theory that applies to lesbians is minority stress, defined as the stress a socially stigmatized individual faces (Meyer, 2003). Another elaboration of this theory is the concept of anomie, coined by Durkheim (1951), which is characterized as a sense of isolation from the majority group and a lack of control over the social environment that can possibly lead to suicidal behaviors due to the individual's basic needs not being met. Thus, this excess stress to which lesbians are exposed may have a direct negative impact on their physical health through the possible occurrence of anxiety, depression, suicidal ideation or disordered eating.

Lesbians and CSA. Recent findings suggest CSA is more frequently reported by lesbians than by heterosexual women (Austin et al., 2008). For example, in a secondary analysis conducted by Smith et al. (2010) comparing previous childhood sexual abuse among 392 heterosexual women and 475 lesbians, the latter reported significantly higher rates of both intrafamilial CSA (29.6 percent vs. 16.2 percent) and extrafamilial CSA (30.7 percent vs. 14.3 percent) than their heterosexual counterparts. Covariates of Smith et al.'s study included self-reported sexual abuse, sexual orientation, demographic factors, and a history of depression or anxiety. Their study revealed associations among African Americans, lesbian sexual orientation, intrafamilial CSA and a history of depression and/or anxiety. Bowen (2008) explains that sexual minority women tend to deviate from traditional norms of society and thus are not as concerned with conforming to these normalized standards of physical appearances. Research suggests that youth who deviate from these traditional gender roles are more likely to be targets for abuse (D'Augelli et al., 2006). D'Augelli et al. analyzed childhood gender atypicality, lifetime victimization based on sexual orientation, and posttraumatic stress disorder (PTSD) among 528 lesbian, gay and bisexual youth. Victimization began at age 13 with verbal attacks occurring as

early as age 6, physical attacks occurring as early as age 8, and sexual attacks at 9. D'Augelli et al. found PTSD occurred in 9 percent of youth and was association with past physical victimization.

Sexual minority youth may also experience a sense of abnormality due to their sexual orientation. This experience of internal conflict can heighten their risk of engaging in the misuse of drugs. Such behavior could put them at elevated risks for abuse by family members or other children (Austin et al., 2008).

Obesity and Previous CSA Among Lesbians. Such gender atypical behavior may also play a role in lesbians' attitudes toward obesity. Dworkin (1989) theorized that all women, regardless of their sexual orientation, are exposed to the same notion of what is considered to be ideally attractive in the physical sense and are therefore fully aware of the traditional norms concerning body image. However, Bergeron (1998) indicates that due to their overall rejection of traditional gender roles, lesbians tend to worry less about their own body image and are less concerned with the physical attractiveness of potential intimate partners than are heterosexual women. Thus, these theories suggest that since lesbians tend to be less "appearance-oriented," this internalization of social norms may directly affect their weight (Gettelman & Thompson, 1993, p. 548).

One particular explanation as to why sexual abuse may contribute to obesity is that some female survivors of sexual assault may become obese as a protective strategy in order to actively avoid sex in relationships or to prevent potential sexual predation (Smith et al., 2010). In addition, Smith et al. (2010) theorized that survivors of sexual assault may maintain a higher body weight to avoid being sexually objectified. Thus, it has been found that some women with histories of sexual abuse have a "barrier weight," where gaining weight is the objective in order

to be seen as less attractive or to obtain a differently sized body than they had at the onset of their sexual abuse (Smith et al., 2010, p. 1525). Smith et al. (2010) also report that some survivors of sexual assault struggle with weight loss, as they can experience PTSD-related symptoms once they become closer to their weight at the time of their sexual abuse (Smith et al., 2010). Therefore, among lesbians who have experienced previous CSA, these interferences of avoiding sexual predation by attaining a "barrier weight" (Smith et al., 2010, p. #) may cause some lesbians to lack the motivation needed in order to successfully lose weight.

Conceptual Framework

Lesbians. Gonsiorek et al. (1995) define *sexual orientation* as the "erotic and/or affectional disposition to the same and/or opposite sex" (pp. 40-41). Additionally, Muise et al. (2010) distinguish *sexual identity* from sexual orientation as the defining of oneself as a sexual being, a process that includes broader dimensions of sexual orientation. These dimensions may include forms of sexual activities and preferences and sexual desires and needs in the form of sexual partners. Moreover, Worthington et al. (2002) note that the concept of sexual identity and the process of acknowledging one's sexual orientation is an additional characteristic of one's sexual identity. Vrangalova (2012) explains that women who identify as having a lesbian sexual orientation are attracted to and fantasize about women but not men, and have/desire sexual relationships with women but not men.

Current weight. The *American Heritage Stedman's Medical Dictionary* (2002) defines *body mass index* (BMI) as "a measurement of the relative percentages of fat and muscle mass in the human body, in which mass in kilograms is divided by height in meters squared and the result used as an index of obesity" (p. 1). The National Heart, Lung and Blood Institute (NHLBI, 2012) classifies the following measurements using BMI categories: 18.5-24.9 as

healthy weight, 25.0-29.9 as overweight, 30.0-34.9 as mildly obese, 35.0-39.9 as severely obese, and BMI >40 as morbidly obese. Thus, BMI is therefore a measure of healthy vs. unhealthy weight.

Previous CSA. The phrase *childhood sexual abuse* has a wide array of definitional variations and may be part of the reason why establishing accurate prevalence rates poses some difficulty. Due to these differing definitions, the 2010 Federal Child Abuse Prevention and Treatment Act (CAPTA) enforced a standard definition to abide by when assessing for child abuse. CAPTA's definitions of sexual abuse includes "the employment, use, persuasion, inducement, enticement, or coercion of any child to engage in, or assist any other person to engage in, any sexually explicit conduct or simulation of such conduct" (p. 6) or "the rape, and in cases of caretaker or inter-familial relationships, statutory rape, molestation, prostitution, or other form of sexual exploitation of children, or incest with children" (p. 6). Additionally, one must be under the age of 18 to be classified as a child (U.S. DHHS, 2010). Prevent Child Abuse America defines CSA as "Sexual abuse of a child is inappropriately subjecting the child to sexual contact, activity, or behavior" (p. 1).

Background

Lesbians and Obesity. Recent surveys completed by lesbians have depicted them as more prone to being overweight and/or obese than heterosexual women. In a secondary analysis with a sample size of 93,311 participants in the Women's Health Initiative (WHI), Valanis et al. (2000) analyzed heterosexual and non-heterosexual women 50 to 79 years old in order to identify any associations for developing particular diseases. Psychosocial risk factors, recency of screening tests and other health-related behaviors were assessed on the WHI baseline questionnaire. Valanis et al. found that lesbian and bisexual women, although of higher

socioeconomic status than heterosexual women, more frequently used alcohol and cigarettes, exhibited additional risk factors of reproductive cancers and cardiovascular disease and scored lower on measures of social supports and mental health. Findings also suggested that 51 percent of lesbians were classified as being overweight or obese compared to their heterosexual counterparts. Furthermore, research has also indicated that there may be a relationship between morbid obesity and sexual abuse history. Thus, Wadden et al. (2006) conducted a cross-sectional survey comparing psychosocial status and weight loss expectations among women with extreme obesity. The sample included 239 obese women who responded to advertisements for a weight loss study using diet and exercise. Findings indicated that women categorized as class III obese (morbidly obese) are significantly more likely to have disclosed any history of sexual abuse than those women who classified as being class I obese (mildly obese) or class II obese (severely obese). Women with a class III obesity had a mean BMI of 52.6 and age of 41.1. Women with class I-II obesity had a mean BMI of 33.8 and age of 49.2.

Lesbians' Attitudes Toward Obesity. Some studies have found lesbians to have more positive attitudes about their body image than heterosexual women (Bergeron, 1998). More specifically, Roberts et al. (2010) conducted a qualitative study with the aim of identifying any relationships among attitudes and beliefs about overweight/weight reduction in lesbians. The sample consisted of women over the age of 21 who self-identified as lesbian and reported one or more cardiovascular risk factors. The sample was recruited from medical providers and community resources. A total of 25 women completed the study. Findings indicated that the age of the respondent was significant when assessing attitudes toward obesity among lesbians in their study. Thus, younger lesbians seemed to be more concerned about their weight than older lesbians. Roberts et al. (2010) attributed this finding to the potential influence that the Women's

Movement had on lesbians in the 1960s and 1970s, suggesting that because study respondents were influenced by feminism, they were more likely to reject social constructs and therefore be less concerned with their body image (Roberts et al., 2010). Some evidence also suggests that lesbians are generally more attracted to women who are at a higher weight than to women who are at a lower weight (Swami & Tovee, 2006). One cross-sectional study of 72 nonfeminist heterosexuals, 38 feminist heterosexuals, 75 nonfeminist lesbians, and 33 feminist lesbians, conducted by Swami & Tovee (2006), assessed for relationships among lesbian identity and feminist identity in order to establish predictors of physical attractiveness among females. Participants were recruited through advertisements that invited participation in a study about attitudes of women toward their bodies. Heterosexual women identifying as feminists (38) or non-feminists (72) as well as a number of lesbians identifying as feminists (33) or non-feminists (75) were instructed to rate pictures of women according to their physical attractiveness. These pictures portrayed women of varying weights who were known to the experimenters. Weight was established to be an important variable of assessing physical attractiveness (Swami et al., 2006). The figure of a woman with a BMI of 21 kg/m2 was found to be the most physically attractive to heterosexual women, while the figure of a woman with a BMI of 23 kg/m2 was found to be the most attractive to lesbians.

Previous CSA Among Lesbians. Research indicates that CSA may have been experienced in more severe forms for lesbians than for heterosexual women (Austin, 2008). An example of a more severe form of CSA would be forced sexual penetration, and a less severe type of CSA would be indecent exposure or some form of nonconsensual sexual touching (Austin, 2008). In one study of 120 women conducted by Hughes et al. (2001) analyzing lesbians' and heterosexual women's experiences of sexual assault in order to identify any

relationships between sexual assault and alcohol use, lesbians (63) were significantly more likely than their heterosexual counterparts (57) to report the following types of CSA: vaginal penetration, anal penetration, younger age at their first CSA, a larger number of assailants, more frequent CSA, longer duration of CSA, more painful CSA, as well as physical injury that stemmed from CSA. Lesbians were also significantly more likely than heterosexual women to report CSA where the grandfather, stepfather, and uncle were the perpetrators (Hughes et al., 2001). Participants were recruited in this cross-sectional survey through means of advertisements such as flyers and newspapers. Hughes et al. (2001) used a slightly adapted version of the interview questionnaire from the National Study of Health and Life Experiences of Women (NSHLEW), which is a longitudinal study analyzing women's drinking patterns. Findings indicate the possibility that intrafamilial CSA, as opposed to extrafamilial CSA, may cause a heightened risk of obesity for lesbians (Smith et al., 2010).

Summary

There has been little research concerning the relationships between lesbians' risk of obesity and childhood sexual abuse, as well as studies of lesbians' attitudes toward obesity. Studies have stated that lesbian women are at higher risk of obesity as well as childhood sexual abuse than heterosexual women. As mentioned previously, Valanis et al. (2000) found that 51 percent of lesbians were classified as being overweight or obese compared to their heterosexual counterparts in their secondary analysis. Findings also indicated that there may be a relationship between morbid obesity and sexual abuse history and thus further research is warranted. Additionally, Wadden et al. (2006)'s findings in their cross-sectional survey indicated that women categorized as class III obese (morbidly obese) are significantly more likely to disclose any history of sexual abuse than those women who are classified as being class I obese (mildly

obese) or class II obese (severely obese). Hughes et al.'s (2001) findings indicate that lesbians are also significantly more likely than heterosexual women to report CSA where the grandfather, stepfather, and uncle are the perpetrators. However, there are limitations that need to be noted concerning these three studies in regards to sampling, measurement and representativeness of the samples. Valanis et al.'s (2000) sample consisted of older lesbians from 50 to 79 years of age; thus, this sample is only generalizable to lesbians within that age bracket. Additionally, Wadden et al.'s (2006) survey is only generalizable to those lesbians who are actively seeking weight loss treatment. Hughes et al.'s (2001) cross-sectional study suffered from a lack of random selection and consisted of a relatively small sample size and thus limits the generalizability of the findings. It is also important to note that these studies consisted of self-reported findings and thus the reliability of findings is of concern.

The literature also shows lesbians to be more likely than their heterosexual counterparts to have attitudes that are more positive about their own body image and to be attracted to women with higher weights. Roberts et al.'s (2010) findings suggested younger lesbians to be more concerned about their weight than older lesbians. Swami & Tovee's (2006) findings indicated that lesbians are more likely than their heterosexual counterparts to be attracted to women with a higher BMI. Limitations were present in Roberts et al.'s (2010) findings through the small sample size, the lack of diversity within the sample, and possible interviewer bias being evident. Limitations within Swami & Tovee's (2006)'s study consisted of participants' responses of attractiveness being based on their own standards for their own bodies rather than standards they would apply when selecting a partner. Both of these studies' findings also consisted of self-reported findings and thus these findings represent low reliability.

There are gaps in research regarding the relationship among lesbians' history of childhood sexual abuse and their attitudes toward obesity. Thus, this study aims to fill this gap in research by identifying interrelationships among lesbians' attitudes toward obesity, current weight, and history of childhood sexual abuse. This study also employs an internet-based survey due to its convenience, easy attainability, quick responses, and low cost, whereas previously reviewed studies did not.

Hypotheses

H1: The study's variables – lesbians' attitudes toward obesity, BMI, and CSA – will all be significantly, positively correlated.

H.1.1: CSA will be significantly positively correlated with BMI. Lesbians with a history of CSA will have higher BMIs than those without a history of CSA.

H.1.2: Lesbians' attitudes will be significantly positively correlated with CSA. Lesbians with a history of childhood sexual abuse will demonstrate more accepting attitudes toward being overweight and obese.

H.1.3: Lesbians' attitudes will be significantly positively correlated with BMI. Lesbians with a higher BMI will demonstrate more accepting attitudes toward being overweight and obese.

H.1.4: Lesbians' attitudes will be significantly positively correlated with the interaction between BMI and CSA. Lesbians with both a high BMI and a history of CSA will demonstrate more accepting attitudes toward being overweight and obese.

H2: Lesbians will report significantly different attitudes toward BMI based on their own BMI and history of CSA.

H2: Significant mean differences in attitudes toward BMI will exist between the following four groups: (a) lesbians with histories of CSA who also have high BMIs, (b) lesbians who have histories of CSA and low BMIs, (c) lesbians who have no histories of CSA and high BMIs, and (d) lesbians who have no histories of CSA and low BMIs.

CHAPTER 3
METHODS

Study Design

The study used a correlational, cross-sectional research design to examine interrelationships among previous CSA, current weight, and attitudes toward obesity in lesbians. Participants were provided with a survey instrument to collect data pertaining to these variables.

Participants

Description. This study was open to any female 18 years or older who identified herself as a lesbian or who acknowledged experiencing any same-sex attraction. There were no additional requirements for participating. Surveys of respondents who did not identify themselves as lesbian or same-sex attracted were excluded. The sample consisted of 85 participants. This study was geared toward those lesbians who had internet access and its sample largely consisted of those residing in Louisiana and the southernmost part of the United States.

Human Subjects Protection. Louisiana State University Institutional Review Board approval was sought for this study. Participation in this study was voluntary, and informed consent was indicated by participants' submission of a completed survey that began with a brief explanation of the study and his or her rights as a study participant. This study posed minimal psychological risk through survey questions to participants. No identifying information was asked of the participants; their identity remained anonymous.

Procedures

Participants were recruited through different networking media such as word of mouth, LGBTQ organizations such as Capital City Alliance, various social media sites such as Facebook, and e-mail announcements through the Louisiana School of Social Work. The full survey was administered to all participants. The survey took approximately 10 to 15 minutes to

complete and was administered via an online survey site – surveymonkey.com. The URL to the survey was posted on social media sites and was distributed through e-mail announcements where the participants could easily access and complete the survey. The survey consisted of three sections – height/weight, attitudes toward obesity, and demographics – 29 total questions.

Measures

Body Mass Index. After agreeing to the informed consent, participants were first asked to provide their weight and height at the beginning of the survey. This information was used to calculate their BMI through the use of the National Heart Lung and Blood Institute's online BMI calculator (U.S. DHHS, 2012).

Childhood Sexual Abuse. In order to assess for history of childhood sexual abuse among participants, a definition explaining what constitutes childhood sexual abuse was provided at the beginning of the survey. Prevent Child Abuse America defines CSA as "Sexual abuse of a child is inappropriately subjecting the child to sexual contact, activity, or behavior" (p. 1). Participants were then instructed to check "yes" if this definition applied to them and "no" if it did not apply to them.

Attitudes. Lesbians' attitudes toward obesity were measured using The Attitudes Toward Obese Persons Scale (ATOP), which has been utilized in previous studies (e.g., Allison et al., 1990) assessing for attitudes toward overweight and obesity among undergraduate psychology students. The ATOP scale is a 20-item six choice Likert-type scale measured on a range from 1, *strongly agree*, to 6, *strongly disagree* (Allison et al., 1990). Some items for the scales were adapted from the Attitudes Towards Disabled Persons Scale (ATDP) while other items were developed by the authors (Allison et al., 1990). The authors found the ATOP scale to have an alpha reliability range of .80 to .84. Higher scores reflected a higher level of acceptance

toward obesity, and lower scores indicated a lower level of acceptance toward obesity. The ATOP is scored by reversing 13 items and summing the 20 item scores. The total ATOP scale score ranges from 12 to 108, with higher values indicative of more positive attitudes toward obesity. To account for any absent values and in order to standardize scores, total scores were divided by the number of valid values.

Demographics. Questions concerning socio-demographic information were asked including age, gender, sexual identity, race/ethnicity, income, educational attainment, and employment status.

Data Analysis

Data was analyzed using PASW v.20. A power analysis revealed that in order to detect a medium effect size (.60) at the .05 level of significance with a statistical power of .83-.86, a sample size consisting of 80-100 is ideal (Rubin & Babbie, 1993). Pearson's correlation coefficient was computed to assess interrelationships among interval-level (attitudes) and ratio-level (BMI) variables. Point-biserial correlation coefficient was used to assess interrelationships among the nominal-level variable (CSA) and the two continuous variables (attitudes and BMI). A one-way analysis of variance (ANOVA) was conducted to compare mean differences in attitudes between the four groups of lesbian respondents: low-BMI/CSA-yes; the low BMI/CSA-no; high-BMI/CSA-yes; and high-BMI/CSA-no. Low BMI consisted of a BMI of 24.9 or lower, and high BMI consisted of a BMI of 25 or higher.

Independent Variables. Childhood sexual abuse was treated as a dichotomous nominal variable, and BMI was treated as a ratio-level variable. All demographic data are nominal variables except age, which is a ratio-level variable.

Dependent Variable. Attitudes toward obesity was treated as an interval-level variable.

CHAPTER 4
RESULTS

One hundred twenty-two people started the survey, with one participant failing to give consent, resulting in 121 people. Five were excluded for identifying their gender as male (n = 2), transgender (n = 2), and other (n = 1). The males and transgender participants could not be confirmed as transgender men (i.e., born and, presumably, having lived the first several years of their lives as females), and the individual identifying as "other," specifically "third gender," also cannot be confirmed as female or a transgender man. Five others were excluded for identifying their sexual identity as heterosexual (n = 3) and questioning (n = 2). These individuals could not be confirmed as transgender male heterosexuals in the case of the former or as lesbians or bisexual women in the case of the latter. One was excluded for not responding to the CSA item. Twenty-five were excluded for not completing the survey, resulting in a final sample of 85. Frequency data for demographic and study variables are reported in Table 1.

Sample Characteristics

As seen in Table 1, over half of respondents self-identified as lesbians (57.6%), and just under one third self-identified as bisexual (29.4%). A majority of respondents self-identified as white (81.2%) and being a college student (41.2%) or employed full-time (47.1%). The mean score on the ATOP scale was 79.3 (with the possible range of scores being 12 to 108). This score indicates an overall high level of acceptance toward obesity. The mean BMI of respondents was 28.86, the mean age of respondents was 28.33 and the percentage of respondents who self-reported having experienced previous CSA was 37.6%. The percentage of respondents being obese was 12.6 %.

Table 1

Demographic and Study Variables (N = 85)

Variable	*%(n)*	*M(SD)*
Gender		
Female	98.8(84)	
Other	1.2(1)	
Sexual Identity		
Lesbian	57.6(49)	
Gay	1.2(1)	
Bisexual	29.4(25)	
Queer	4.7(4)	
Same-sex attracted	4.7(4)	
Other	2.4(2)	
Ethnicity		
White	81.2(69)	
Black	9.4(8)	
Latino	2.4(2)	
Biracial	4.7(4)	
Other	2.4(2)	
Employment		
Homemaker	1.2(1)	
Full-time	47.1(40)	
Part-time	8.2(7)	

(Table 1 continued)

Variable	*%(n)*	*M(SD)*
Unemployed	2.4(2)	
College student	41.2(35)	
Educational Attainment		
Still in high school	1.2(1)	
High school/GED	2.4(2)	
Some college	23.5(20)	
Bachelors degree	32.9(28)	
Masters degree	24.7(21)	
Doctoral degree	1.2(1)	
Attitudes toward obesity		79.3(13.43)
BMI		28.86(8.47)
CSA (yes)	37.6(32)	
Age		28.33(7.29)

Hypothesis 1 was tested using correlational analyses among key study variables (i.e., attitudes toward obesity [ATOP], weight [BMI], and previous childhood sexual abuse [Previous CSA]), and are reported in Table 2. Previous CSA was found to be significantly negatively correlated with BMI. Thus, BMI increased among respondents who reported having no history of previous CSA. No other significant interrcorrelations emerged.

Table 2

Correlations Among Study Variables (N = 85)

Study Variables	1	2	3
1. ATOP Score	--		
2. BMI	.040	--	
3. Previous CSA	.055	-.241*	--

Note. ATOP = Attitudes Toward Obese Persons Scale, *p<0.05

Hypothesis 2 was analyzed using an ANOVA to compare the mean attitudes toward obesity of those with a dichotomized high/low BMI and a history or no history of CSA. Table 3 reports the total ATOP scale score means and standard deviations for the groups created from the four possible independent variable combinations.

Table 3

Means and Standard Deviations for Four Independent Variable Combinations and Attitudes toward Obesity

	Low BMI/ CSA (*n* = 30)	Low BMI/ no CSA (*n* = 7)	High BMI/ CSA (*n* = 23)	High BMI/ no CSA (*n* = 25)
Variable	*M (SD)*	*M (SD)*	*M (SD)*	*M (SD)*
Obesity attitudes	80.8 (13.0)	78.3 (17.6)	78.6 (14.7)	78.3 (12.2)

No significant differences in mean total ATOP scores emerged, indicating no effect of the BMI/CSA grouping on attitudes $F(3, 81) = .191$, $p = .902$ (see Table 4).

Table 4

One-Way Analysis of Variance Summary for Independent Variable Combinations

Source	*df*	*SS*	*MS*	*F*
Between groups	3	106.59	35.53	.191
Within groups	81	15051.71	185.82	
Total	84	15158.31		

CHAPTER 5
DISCUSSION

The rates of CSA within this study were not consistent with those found in reports and previous studies. Thus, 37.6 percent (32 people) of the sample reported experiencing previous CSA while the vast majority of lesbians mentioned in previous studies have experienced previous CSA. Overweight and obesity rates, on the other hand, were consistent with those found in reports and previous studies with the BMI of respondents being 28.86 which falls toward the higher end of the overweight category of BMI ranges (25.0 – 29.9).

This study examined the interrelationships among childhood sexual abuse, BMI, and attitudes toward obesity, using a sample of 85 lesbians and bisexual women. A significant negative correlation between childhood sexual abuse and BMI emerged (hypothesis 1.1) but there were no significant associations among lesbians' attitudes toward obesity and childhood sexual abuse (hypothesis 1.2) or lesbians' attitudes toward obesity and BMI (hypothesis 1.3). An ANOVA revealed no significant difference between mean total ATOP scale scores among any of the four independent variable combinations (low/high BMI and yes/no CSA), indicating that there was no effect of the BMI/CSA grouping on attitudes.

The significant negative correlation in this study between CSA and BMI do not coincide with the results found by Smith et al. (2010) that lesbians with a history of CSA reported higher BMIs than those without a history of CSA. Although the sample was relatively overweight (M = 28.86), this finding may be because the lower-end BMI respondents (M = 22) were not exactly "thin" to begin with. This also may be due to lesbians' rejection of socially constructed norms, which leads to overeating and thus a higher BMI (Bergeron, 1998).

Conversely, the lack of a significant correlation between lesbians' attitudes toward obesity and current BMI was inconsistent with the results found by Roberts et al. (2010), who

noted that lesbians who were overweight or obese themselves were more likely to be accepting of being overweight or obese. Thus, although the respondents' scores on the attitudes scale were generally high (M = 79.3) and therefore demonstrating more accepting attitudes toward obesity, they did not significantly correlate with their own BMI. This may be due to lesbians having less negative attitudes about obesity than their heterosexual counterparts (Smith et al., 2010) regardless of their own BMI.

There was also no significant association among lesbians' attitudes toward obesity and CSA; lesbians with a history of CSA did not report more accepting attitudes toward being overweight and obese than those without a history of CSA. The reason for this departure may be that, although the average BMI of participants in the current study was relatively high (M = 28.86), which falls in the overweight category, lesbians' attitudes toward obesity may have been significantly correlated with CSA if their BMI was at a higher rate. For example, Smith et al. (2010) analyzed their findings based on 35.8 percent of lesbians being obese whereas only 12.6 percent of lesbians were obese in this study. Additionally, assessing the type of sexual abuse (intrafamilial vs. extrafamilial) may have had different effects on attitudes toward obesity due to previous literature suggesting that lesbians with a history of intrafamilial childhood sexual abuse are more likely to be obese (Smith et al., 2010). Thus, those experiencing a history of intrafamilial childhood sexual abuse may have demonstrated more accepting attitudes toward obesity.

Lastly, there were no significant mean differences in attitudes toward obesity existing between lesbians with histories of CSA who also have high BMIs, lesbians who have histories of CSA and low BMIs, lesbians who have no histories of CSA and high BMIs, and lesbians who

have no histories of CSA and low BMIs. Thus, there was no significant difference in attitudes among lesbians based on their own BMI and history of CSA.

The lack of support for 2 of the 3 hypotheses could be due to the geographical locations of the participants. The online survey used in the current study was available to those individuals primarily located in Louisiana and other southern states. Louisiana has a self-reported obesity prevalence rate of 33.4 percent, the second highest in the nation (CDC, 2011). It could be inferred from this high prevalence rate that people, including lesbians, who reside in the South, particularly Louisiana, are more accepting of those who are overweight or obese given the fact that a substantial portion of those living in the south are overweight or obese. Therefore, further research would be needed in order to establish if geographical location influences interrelationships among CSA, BMI, and attitudes toward obesity among lesbians.

Limitations

There are several limitations within this study that should be noted and taken into consideration, the first being the limited sample size. A substantial number of participants had to be excluded from the study for eligibility reasons based on their sex or sexual orientation, and several others were excluded for not completing the survey. The small sample size, although within the bounds of that recommended by the power analysis, may have resulted in a lack of representation of the lesbian population in the United States. With the overwhelming majority of respondents being young, Caucasian, and residing in Louisiana, the lack of diversity in race/ethnicity, age, and geographical location should also be considered. Thus, the findings of the current study are generalizable to lesbian women living in the South. Specifically, previous literature states obesity is more prevalent among African-American lesbians than Caucasian women (Smith et al., 2010).

An additional limitation worth noting is the potential for the respondents to have reported inaccurate personal information pertaining to their weight and CSA history. Even though the survey was anonymous and therefore the risk of participants providing false information was low, this should still be taken into account when analyzing the results. Inaccurate reporting, whether intentional or unintentional, affects the validity of the data and thus impacts the findings of the study. Additionally, the findings in this study relating to CSA history are based on responses to one question that asked about self-perceived CSA during childhood according to the definition provided. Interpretation of experiences during childhood likely varied among participants and thus it is possible that CSA may have been underreported because some women may not consider their experiences as abuse so the true relationship between CSA and obesity among lesbians may be underestimated. The relationship between the type of CSA (intrafamilial vs. extrafamilial) and the type of obesity (class I, class II, or class III) may also be underestimated considering that these aspects were not assessed in the current study. Roberts et al. (2010) found that intrafamilial CSA was an independent predictor of obesity, and those who were class III obese were more likely to report physical and sexual abuse than those who were class I and class II obese. Thus, those respondents who may have experienced intrafamilial CSA may have demonstrated more positive attitudes toward obesity.

This study also did not assess for lifetime history of obesity or the onset of obesity in relationship to CSA. Thus, longitudinal studies would be needed in order to determine the relationship between obesity and similar issues over time. It is also important to take into consideration that this study represents lesbians who are "out of the closet" to some degree; therefore, these results describe lesbians who are comfortable with reporting their sexual orientation.

Another limitation of this study was the use of mean imputation as a replacement for missing values in the ATOP scale which can potentially skew the data. By choosing a single imputation the true value is not known with certainty and thus the standard errors of estimates may remain too low (Little, 2001). Another limitation that must be noted is the self-selection bias of an online survey as well as the potential for respondents to have reported inaccurate information specifically regarding height, weight, and previous CSA. These limitations must be noted when analyzing the results and must be taken into consideration for future research of these issues.

Implications for Practice

Despite these limitations, the study provided evidence that lesbian and same-sex-attracted women are at high risk for being overweight or obese. Overweight and obesity are recognized as preventable deaths. Specifically, recent studies have found that only obesity, not being overweight, is a direct link to an increase in deaths related to illnesses such as hypertension, type 2 diabetes, coronary heart disease, stroke, gallbladder disease, sleep apnea, and colon, endometrial, breast and prostate cancers (Boehmer et al., 2007). Therefore, it is critical that weight loss interventions be implemented specifically targeting sexual minority females.

Both physical and mental healthcare providers should be aware that there are elevated rates of obesity among sexual minority women. Clinicians must address these health needs in research, medical education, and direct clinical practice with lesbian and bisexual women. It would benefit all social workers to receive training that would allow them to competently provide empathetic and sensitive care for sexual minorities in order to improve their emotional well-being. It may also benefit all health care professionals to receive a certain degree of skill

training to care for sexual minority patients in order to improve their physical health. Additionally, it is paramount for sexual minorities to receive health education, as it seems from previous literature that very few lesbian and bisexual women display health-seeking behaviors due to the lack of sensitivity among health care practitioners (McNair, 2003). This lack of such behaviors may possibly impact their health. Thus, this relates to the previously stated notion that more sensitivity training is needed among health care providers because it may allow sexual minorities to feel more comfortable when going to the doctor.

Furthermore, clinicians should be mindful for assessing for previous childhood sexual abuse among lesbian and bisexual women. Experts in working with survivors of sexual assault agree that the most effective approach is phase-oriented, which segregates treatment into phases or stages that each focus on individual goals or objectives (Brown et al., 1998). A phase-oriented approach to treatment will aid the social worker in delineating a clear treatment path, eventually using techniques such as mindfulness to rid maladaptive behaviors such as overeating (Brown et al., 1998). Clinicians also need to be willing to focus on the client's sexual trauma and her feelings related to the trauma in order to serve as a pertinent role in helping women cope with their experiences.

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APPENDIX: SURVEY

Before completing the survey, please answer a couple of questions regarding your weight and height.

1. How tall are you (in feet and inches)? _____
2. How much do you weigh (in lbs)? _____

Please mark each statement below in the left margin, according to how much you agree or disagree with it. Please do not leave any blank. Use the numbers on the following scale to indicate your response. Be sure to place a minus or plus sign (- or +) beside the number that you choose to show whether you agree or disagree.

-3	-2	-1	+1	+2	+3
I strongly disagree	**I moderately disagree**	**I slightly disagree**	**I slightly agree**	**I moderately agree**	**I strongly agree**

1. _____ Obese people are as happy as nonobese people.
2. _____ Most obese people feel that they are not as good as other people.
3. _____ Most obese people are more self-conscious than other people.
4. _____ Obese workers cannot be as successful as other workers.
5. _____ Most nonobese people would not want to marry anyone who is obese.
6. _____ Severely obese people are usually untidy.
7. _____ Obese people are usually sociable.
8. _____ Most obese people are not dissatisfied with themselves.
9. _____ Obese people are just as self-confident as other people.
10. _____ Most people feel uncomfortable when they associate with obese people.
11. _____ Obese people are often less aggressive than nonobese people.
12. _____ Most obese people have different personalities than nonobese people.
13. _____ Very few obese people are ashamed of their weight.

14. _____ Most obese people resent normal weight people.

15. _____ Obese people are more emotional than nonobese people.

16. _____ Obese people should not expect to lead normal lives.

17. _____ Obese people are just as healthy as nonobese people.

18. _____ Obese people are just as sexually attractive as nonobese people.

19. _____ Obese people tend to have family problems.

20. _____ One of the worst things that could happen to a person would be for him to become obese.

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21. According to Prevent Child Abuse America (a national nonprofit organization), childhood sexual abuse is defined as, "inappropriately subjecting the child to sexual contact, activity, or behavior." Please indicate if, according to this definition, you believe you experienced sexual abuse as a child (ages birth through 18).
    - ❑ Yes
    - ❑ No

(If you are looking to receive advocacy, emotional support, or education regarding sexual abuse, please contact the Sexual Trauma Awareness and Response Center at 225-383-7273).

Demographics:

Please tell us about yourself.

22. How old are you? (Please indicate a number, not a range.)

    Age in years: _____

23. What is your gender? (Please check one.)
    - ❑ Female
    - ❑ Male
    - ❑ Transgender
    - ❑ Intersex
    - ❑ Other _____

24. What is your sexual identity? (Please check one.)
- ❑ Lesbian
- ❑ Gay
- ❑ Bisexual
- ❑ Queer
- ❑ Questioning
- ❑ Same-sex attracted
- ❑ Heterosexual/Straight
- ❑ Other _____

25. How do you identify in terms of your race? (Please check one.)
- ❑ European American or White, not of Hispanic Origin
- ❑ African American or Black
- ❑ Hispanic/Latino
- ❑ Native American/American Indian/Alaska Native
- ❑ Asian American or Asian
- ❑ Native Hawaiian or Other Pacific Islander
- ❑ Biracial/Multiracial (Please specify)
- ❑ Other _____

26. What is your primary employment status? (Please check one.)
- ❑ Homemaker
- ❑ Full-time
- ❑ Part-time
- ❑ Retired
- ❑ Unemployed
- ❑ Other _____
- ❑ College student

27. What is the highest educational level you have completed? (Please check one.)
- ❑ Still in high school/GED program
- ❑ Less than high school diploma
- ❑ High school diploma/GED
- ❑ Some college
- ❑ Bachelor's degree
- ❑ Some graduate school
- ❑ Master's degree
- ❑ Doctoral degree

VITA

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Amy resides in Baton Rouge, Louisiana, with her partner. She plans to stay involved with the Baton Rouge Crisis Intervention Center as well as pursue her Ph.D. in Social Work at LSU starting in the fall of 2013. She hopes to continue her work with the LGBTQ population via direct practice, advocacy, and research.