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Intimate partner violence and eating disorders: a systematic review

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Abstract

Eating disorders are one of the consequences suffered by individuals who are immersed in intimate partner violence. Knowing that intimate partner violence is a social problem that affects men and women all over the world, it is important to examine and detect which factors affect their physical and emotional health. The aim of the present work was to systematically review the association between IPV and ED. In February 2024, a systematic search of Web of Science, Scopus and PsycINFO databases was performed. A total of 689 papers were obtained, of which 155 were excluded as duplicates, resulting in 535 articles. After reviewing the title, abstract and keywords, 485 articles that did not meet the inclusion criteria were eliminated. Subsequently, the remaining 50 papers were read and discrepancies were resolved, achieving 87.3% agreement among judges. Finally, 40 papers met the inclusion criteria and were included in the systematic review. The results clearly show the relationship between IPV and various EDs. Being a victim of IPV, in its different forms (physical, psychological and sexual), has been related to disorders such as anorexia nervosa, bulimia nervosa and binge eating disorder. In general, some studies found differences between men and women in the association of the presence of sexual violence and ED symptoms. In conclusion, EDs may be a form of control that individuals exert over their bodies in response to the control exercised by their abusive partners. Addressing the interpersonal sphere by focusing on the management of violent dynamics within the couple is the key to change in individual coping.

Keywords Intimate partner violence · Type of violence · Anorexia nervosa · Bulimia nervosa · Binge eating disorder

Intimate Partner Violence (IPV) and Eating Disorders (ED) have a great impact on the physical and mental health of individuals (Laskey et al., 2019; Oram et al., 2013), thus representing crucial public health issues worldwide. IPV affects millions of people (641.000.000), especially women, in all regions of the world (World Health Organization; [WHO], 2021). EDs, which mainly include Anorexia Nervosa (AN), Bulimia Nervosa (BN) and Binge Eating Disorder (BED) are serious mental disorders that not only compromise the physical health, but also the emotional and social health of those who suffer from them (American Psychiatric Association [APA], 2013). In quantitative terms, such eating disorders affect more than 30 million people and are a significant cause of mortality (Kutz et al., 2020). These two variables have been exhaustively studied independently (e.g., Ali et al., 2016; Le et al., 2017), however, the interconnection between IPV and EDs is increasingly recognized (Claydon et al., 2024), it being important to clarify the association between them. Since the psychopathological impact that IPV triggers in victims is strongly associated with depressive and anxiety-like pathological symptomatology that has a high degree of comorbidity with ED (Amor et al., 2002), it is vital to understand the mechanisms underlying the relationship between IPV and the ED symptomatological picture itself. In this way, we would have a better understanding of the processes involved in the appearance of ED symptomatology and which variables could be triggering them.

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When examining the different dimensions encompassed by the ED, it is essential to understand the responses that individuals with ED may have when they are victims of violence. In fact, understanding this aspect not only contributes to the understanding of abuse and its prevention, but also provides valuable tools for therapists to identify the behaviors exercised by both the victim and the aggressor, so that they can work on these problems and pathologies more effectively (Clavijo Campoverde et al., 2021). Finally, it should be noted that it is also essential to delve deeper into the factors that mediate between IPV and ED, in order to better understand the complex relationship and thus have complete and detailed information (Lucea et al., 2012).

Therefore, this systematic review has a twofold objective: a) to explore the relationship between IPV and EDs, analysing how IPV may influence the development and perpetuation of different EDs and their symptomatology and b) to identify the underlying factors that contribute and/or moderate in the relationship between IPV and EDs with the ultimate goal of providing a solid foundation to guide future therapeutic interventions and ultimately contribute to improving the quality of life of those affected by these issues (Lozano-Muñoz et al., 2022).

Theoretical framework

Intimate partner violence (IPV)

IPV refers to acts of aggression, abuse, subjugation and control that occur in a partner relationship (current or past), which may cause physical, psychological or sexual harm (Sardinha et al., 2022). Several studies conducted by organizations such as WHO in 2021 have highlighted the alarming prevalence of IPV worldwide. Specifically, according to data provided by WHO (2021) it is estimated that 27% of women aged 15–49 years have been subjected to physical and/or sexual violence by an intimate partner. It was also found that approximately one in four women and one in ten men have experienced IPV in their lifetime (Sardinha et al., 2022). IPV can have serious physical, mental, and sexual consequences for victims, increasing the risk of depression, post-traumatic stress disorder (PTSD), alcohol and drug abuse, and sexual and reproductive health problems (WHO, 2021).

According to the study by Burgos et al. (2012) there are different forms of violence. On the one hand, economic violence, which involves the control and management of money, property and, in general, all the family's resources. On the other hand, there is psychological violence, a type of violence that manifests itself through shouting, threats, social isolation, jealousy, intimidation, degradation, insults and blame (Burgos et al., 2012). Another type of violence is physical violence, which refers to acts such as hitting, pushing and/or slapping, which can lead to situations that cause physical injury and/or even death (Burgos et al., 2012). This type of violence not only causes immediate physical injury, but also is associated with a number of long-term health problems, including mental disorders such as depression and PTSD (Dillon et al., 2013). Finally, there is sexual violence, which according to the description of Burgos et al. (2012) is exercised through physical or psychological pressures that impose unwanted sexual relations through coercion, intimidation or helplessness.

Research on IPV reveals that both men and women can be perpetrators and victims of violence (Arnoso et al., 2017; Chen & Chan, 2021; Rojas-Solís et al., 2017), an aspect referred to as bidirectional violence (Johnson, 2011). Bidirectional violence is the most common form of violence in couples with an intimate relationship (Muñoz & Echeburúa, 2016). Psychological violence is more prevalent (80%) compared to physical violence (25%) within relationships where bidirectional violence exists (Graña & Cuenca, 2014). In the case of unidirectional violence, also called intimate terrorism (Johnson, 2011), one partner resorts to violent aggression while the other partner is the victim (Ferrer-Pérez & Bosch-Fiol, 2019). Likewise, there are findings that reveal that women are more perpetrators of psychological and mild physical violence and men of severe physical violence (Chen & Chan, 2021; Rubio-Garay et al., 2017).

Regarding the directionality of violence and its consequences on the health of individuals, several researchers are beginning to study both the individual and the partner in relationships in order to better understand the extent of victimization and aggression in these situations (Herrero et al., 2020; Taylor et al., 2019; Xu et al., 2022). Studies focused on analysing the different forms of violence and their consequences on the physical and mental health of individuals have shown that the directionality of violence is associated with both the severity and the symptomatology presented (Chatterji & Heise, 2021), thus being an essential aspect to consider.

Factors influencing the occurrence of IPV

With regard to the development and emergence of violent dynamics, it has been observed that various factors, both individual and social, can facilitate violent interactions in couple`s relationships. Social factors such as social imaginaries that legitimize violence, low educational level, job insecurity, unemployment, machismo and LGTBI-phobia play a determining role. However, other intraindividual factors may also be influencing the occurrence of violence, as well as its consequences. Among the individual factors

we would have those that include psychopathology that the individual may be suffering from such as depression, anxiety, PTSD (Muñoz Fernández et al., 2020), as well as ED (Muñoz Fernández et al., 2020).

Eating disorders (ED)

EDs are complex mental disorders that affect the way people perceive their body and their relationship with food (Uribe et al., 2024). AN, BN and BED are just some of the manifestations of these disorders, which can have serious consequences for the physical and psychological health of those who suffer from them (Carolina & Janet, 2011). According to the DSM-5 (APA, 2013), EDs affect approximately 8.4% of women and 2.2% of men (Galmiche et al., 2019) at some point in their lives, these prevalences being very different depending on the type of ED.

Between 1990 and 2020, deaths caused by EDs have doubled globally. According to the National Eating Disorder Association, an estimated 70 million people have been diagnosed with ED, and a significant increase in ED-related deaths has been observed (Wu et al., 2020). The magnitude of this problem is alarming, and it is crucial to effectively address the prevention, detection, and treatment of EDs to avoid devastating consequences on the health and well-being of affected individuals.

According to the APA (2013), EDs are complex psychological conditions that affect a person's relationship with food, their weight and their body. On the one hand, AN is characterized by extreme restriction in food intake and excessive forms of exercise and/or diuretics, accompanied by an intense fear of gaining weight and a distortion in the perception of one's own body. It can manifest in two forms: restrictive, where weight loss is achieved by dietary restriction; and binge/purge, which involves recurrent episodes of excessive food intake or purging. On the other hand, BN involves recurrent episodes of binge eating, followed by inappropriate compensatory behavior to avoid weight gain, such as self-induced vomiting. The person's self-evaluation is negatively influenced by his or her body weight and shape. Finally, BED also involves recurrent episodes of binge eating, but without compensatory behavior. These episodes are associated with significant distress and do not occur exclusively during episodes of AN or BN.

Although the exact etiology of ED is not fully understood, it has been shown that factors such as cultural pressure to achieve certain standards of beauty may influence the very development of the disorder (Campos del Portillo et al., 2024) and there have even been studies reporting the effects of some social networks on these disorders (Muñiz-Rivas et al., 2020). Similarly, exposure to traumatic experiences and underlying psychological disorders have been relevant and key mediating variables in the development of this psychopathology (López Fernández Cao, 2017), as is depression and anxiety (Lacey & Mouzon, 2016). Regarding relational variables, it is observed, that the development of EDs can also come not only from the intrapersonal variables themselves, but also from the form of relationship of individuals, such as the type of attachment (Valledor et al., 2024). Therefore, we can conclude that it is not only those variables originating from the individual, but also some relational and interpersonal aspects can influence the appearance of the symptomatology associated with ED. However, at present we have little evidence on the impact of all these measures on well-being and the development of new evidence (Graell et al., 2020).

Relationship between IPV and ED

IPV and ED are complex and multidimensional problems, influenced by various individual, relational, contextual, and sociocultural factors. Studies have revealed that women who experience IPV are at increased risk of developing ED, with PTSD and depression as significant mediators in this relationship (Creech et al., 2021). In addition, both IPV and ED share common risk factors, such as exposure to childhood trauma and cultural pressure to meet certain beauty standards (Chen et al., 2024). These factors interact in complex ways, exacerbating the negative effects on the health and well-being of affected individuals.

In the relationship dynamics between the perpetrator and the IPV victim, as well as between the individual and his or her ED, similarities are observed in patterns of control and abuse that negatively impact the lives of affected individuals. These findings highlight the complexity and severity of the effects of IPV and ED on mental and physical health (WHO, 2021), underscoring the importance of addressing these problems in a comprehensive manner and from interdisciplinary approaches (Wuest et al., 2003). Therefore, a systematic review would allow us to better understand this association, as well as to identify mediators and risk factors, and to understand how they affect the health and well-being of affected individuals. This would provide a solid basis for the development of future therapeutic interventions and effective prevention policies to improve the quality of life of individuals in abusive relationships with their partners.

Method

Data collection

This systematic review was conducted taking into account the recommendations of the Preferred Reporting Items for

Systematic reviews and Meta-Analyses (PRISMA) statement (Page et al., 2021). A systematic search was conducted in February 2024, using the following databases: Web of Science, Scopus and APA PsycINFO. Specifically, a search equation combining the following terms was used: "intimate partner violence", "mutual violence", "perpetration", "victimization", "domestic violence", "partner abuse", "partner violence", "spouse abuse", "battered women" and "eating disorder", "eating pathology", "binge eating", "bulimia", "anorexia" and "disordered eating" (see pre-registration for more information: https://osf.io/jvrud/?view_only=c4149d0899644493849731952c8b7611).

Eligibility criteria

We considered studies that met the following criteria: (1) analysed the relationship between IPV and ED symptomatology; (2) papers in article format that had undergone a peer review process; and (3) published in English or Spanish.

On the other hand, the following exclusion criteria were applied: (1) studies in which the type of violence was not specified; (2) theoretical articles; (3) systematic reviews or meta-analyses; (4) single-case studies; and (5) documents that were not accessible.

Selection of studies

The selection of studies was performed independently by three authors of this paper. The initial search yielded 689 papers, of which 155 were excluded because they were duplicates. After reading the title, abstract and keywords of the remaining 536 papers, 485 papers that did not meet the inclusion criteria were eliminated. The 50 papers were then read in full and discrepancies between the two authors were resolved. The degree of agreement between the two judges was high; specifically, they agreed in 87.3% of the cases. Finally, 40 papers met the inclusion criteria and were included in the systematic review (see Fig. 1).

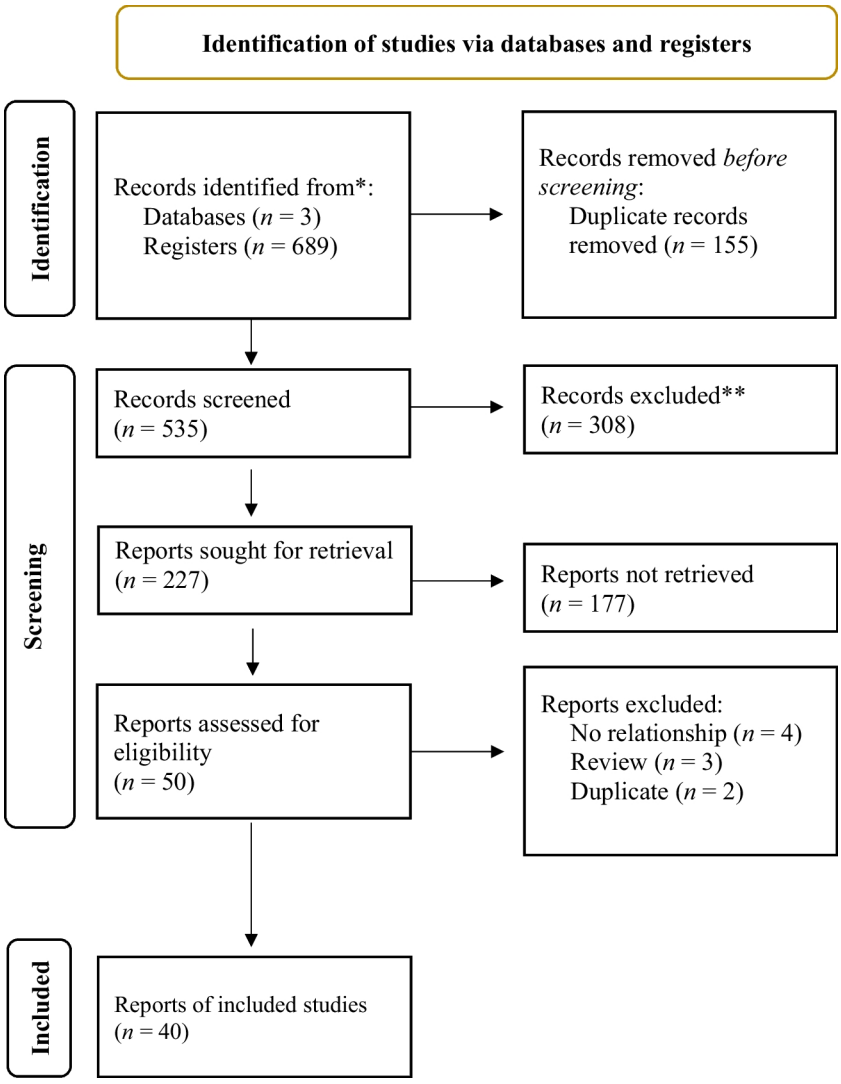

Fig. 1 PRISMA 2020 flow diagram for new systematic reviews which included searches of databases and registers only

Coding studies

Taking into account the guidelines of Lipsey and Wilson (2001), two authors created a coding scheme in which the following information was recorded: authors, title of the document, year of publication, study design, sample size, information regarding the age of the participants (mean, standard deviation, range), percentage of women, place of residence, type of sample (clinical vs. non-clinical), measurement instruments used, sexual orientation of the partners, type of violence (physical, psychological, sexual…), direction of partner violence (male to female, female to female…), objective and main results.

Results

Sample and instruments used

Of the total number of studies analysed, 38 of these studies were quantitative and the remaining two were qualitative. Likewise, with regard to the type of research design, 35 studies of those studies were cross-sectional and five longitudinal ones.

The studies identified in this review written in Spanish and English were published between 1989 and 2024: 1989 ($n=1$), 2002 ($n=1$), 2003 ($n=1$), 2006 ($n=1$), 2009 ($n=1$), 2012 ($n=2$, 2013 ($n=4$), 2014 ($n=2$), 2015 ($n=7$), 2016 ($n=4$), 2018 ($n=2$), 2020 ($n=2$), 2021 ($n=4$), 2022 ($n=5$) 2023 ($n=3$) and 2024 ($n=2$). The studies were conducted with samples from several countries such as Portugal, Spain, UK, Turkey, Japan, Iceland, Italy, Canada, Lebanon, Australia and the U.S. Thus, the samples came from the following continents: America ($n=26$), Europe ($n=10$), Asia ($n=2$), Africa ($n=0$) and Oceania ($n=1$) (see Table 1).

It was observed that in almost half of the studies ($n=20$), 100% of the sample was composed of women. In 15 studies, women accounted for more than half of the sample, while in only four studies were men in the majority. Only in two studies was the sample composed exclusively of men.

Regarding the instruments used to measure IPV, various validated questionnaires were found in 54.77% of the studies, while the remaining 45.23% used specific items to assess the type of violence. Among the instruments highlighted, the Humiliate-Afraid-Rape-Kick (HARK) questionnaire was used in three studies ($n=3$), the Hurt-Insult-Threaten-Scream (HITS) in two studies ($n=2$), and the Avon Longitudinal Study of Parents and Children (ALSPAC) in three studies ($n=3$). Other instruments such as Violence Received, Exercised and Perceived in Youth and Adolescent Dating Relationship Scale (VREPS) and Composite Abuse Scale Revised-Short Form (CASR-SF) were used in only one study each ($n=2$). In addition, the Abuse Assessment Screen (ASS), Conflict in Adolescent Dating Relationship Inventory (CARDI), and Extended/Hurt/Insult/Threaten/Scream/Modified Version (EHITS-MV) instruments were also used in a single study each ($n=3$). The Conflict Tactic Scale-2 (CTS-2) questionnaire was used in four studies (n=4), and the Woman Abuse Screening Tool (WAST) instrument in one study ($n=1$).

Regarding the instruments found in the review to measure EDs, 44.18% of the studies used questionnaires or surveys designed to assess EDs. Regarding the instruments to measure EDs, 55.82% of the studies used standardized questionnaires. On the one hand, Eating Disorder Diagnostic Scale (EDDS) was used in three studies ($n=3$), while Eating Disorder Inventory-2 (EDI-2) and the Eating Disorder Examination Questionnaire (EDE-Q) were applied in two and three studies respectively ($n=5$). On the other hand, Eating Attitudes Test (EAT) was used in two studies ($n=2$), and Sick-Control-Fat-Food (SCOFF) was the most used ($n=4$). In addition, Diagnostic and Statistical Manual of Mental Disorders (DSM) was employed in three studies ($n=3$), and World Mental Health Composite International Diagnostic Interview (WHO-CIDI) in two studies ($n=2$). Instruments such as Eating Disorder Screen for Primary Care (EDSPC) and the Questionnaire on Eating and Weight Patterns-Revised (QEWP-5) were used in one study each ($n=2$). Finally, Youth Risk Behaviour Surveillance System (YRBSS) and the Drive for Muscularity Scale (DMS) were also used in one study each ($n=2$).

Relationship between IPV and ED

Overall, Huston et al. (2019) reported that approximately 14.11% met criteria for ED (7.83% BN and 6.28% BED), and 49.42% reported lifetime histories of IPV. The relationship between IPV and EDs has been extensively investigated, revealing a complex and multidimensional connection between these variables. Specifically, Huston et al. (2019) found that IPV history is significantly associated with ED symptoms ($\beta=6.21$, $p=0.03$). Likewise, findings such as those of McGee and Thompson (2013) revealed that adolescent males who reported experiences of forced sexual intercourse were more likely to report disordered eating behavior, with an odds ratio (*OR*) of 2.50, 95% *CI*:1.69–3.70 indicating that victims of sexual victimization have a significantly increased risk of developing unhealthy eating behavior. To conclude, in the study by Huston et al. (2019) it was seen how approximately 14.11% of participants met criteria for some ED, with 7.83% for BN disorder and 6.28% for BED and that ED symptoms were significantly associated with IPV ($\beta=6.21$, $p=0.03$). In turn, Jonas et al. (2014) identified that women who had experienced IPV

Table 1 General results of studies selected for systematic review

Authors (year)	Country	*n*, type of sample and % of women	Type of instrument used for intimate partner violence (type of violence)	Type of instrument used for ED (types of ED/symptoms)	Main results
1. Ackard and Neumark-Sztainer (2002)	USA	81,247 students (50%)	A single two ítems adhoc with yes/no answer. (Violence and Rape)	A single items adhoc with yes/no answers. (Binge eating)	Significant associations were found between disordered eating behaviors and date-related experiences. For girls and boys, results indicate that experiencing date violence or rape is associated with significantly higher rates of binge-eating, fasting or skipping meals, taking diet pills, vomiting, and taking laxatives over the past year than for their peers who have experienced neither date violence nor rape.
2. Ackard et al. (2003)	USA	3,533 students (48.9%)	A single two item adhoc with yes/no answer. (Physical and sexual violence).	A single two item adhoc with yes/no answer. (Dieting and being-purge behaviors)	Violence was significantly associated with dieting and being-purge behaviors. Girls and boys who report both physical and sexual dating violence where significantly more likely than their non-abused peers to report dieting and being-purge behaviors
3. Bailey y Gibbons (1989)	USA	542 students (54.2%)	A single item adhoc with yes/no answer. (Physical violence)	They are based on DSM-III criteria to assess both bulimia symptoms and sub-clinical symptoms. (Bulimia nerviosa)	The relationship between the other forms of victimization (rape, sexual molestation, and partner abuse) are smaller but all in the predicted direction.
4. Bartlett et al. (2018)	USA	837 war veterans (23.7%)	HARK (Humiliation, Afraid, Rape, Kick screening; Sohal et al., 2007) (Physical, sexual and psychological violence)	EDDS (The Eating Disorder Diagnostic Scale; Stice et al., 2000) (Anorexia nervosa, bulimia nervosa, and binge eating disorder)	In the case of men, each type of past-year IPV were significantly associated with Disordered Eating symptoms. In women, the results showed that past-year physical IPV ($\beta = 13.74$, $SE = 3.96$, $p < .01$), sexual IPV ($\beta = 15.37$, $SE = 3.75$, $p < .001$), severe psychological IPV ($\beta = 14.68$, $SE = 3.63$, $p < .001$), and a composite "any IPV" variable ($\beta = 10.54$, $SE = 3.27$, $p < .001$) were all significantly associated with EDDS scores.
5. Bonomi et al. (2013)	USA	585 students (76%)	A single ítem adhoc with yes/no answers. (Physical and psychological violence)	Three questions from the Youth Risk Behavior Surveillance System (Dines, 2010) (Fasted, vomited, or took diet aids to lose weight)	For females, any dating violence victimization was associated with disordered eating (taking diet aids, fasting, vomiting). For males, any dating violence victimization was associated with taking diet aids. Compared to non-exposed females, females with non-physical dating violence only were at increased risk of eating disorders (fasting, $PR = 3.37$; vomiting, $PR = 2.66$),
6. Brewer and Thomas (2019)[1]	USA	84,734 students (67,2%)	A single 2 item adhoc with yes/no answer. (Physical, psychological and sexual violence)	A simple item adhoc	Undergraduate past-year survivors of IPV were more likely than their non-abused peers to report disordered eating ($\beta = 0.36$, $p < .001$),
7. Caceres et al. (2021)	USA	615 women with heart disease (100%)	A single two items adhoc with yes/no answer. (Physical and sexual violence)	A single two items adhoc with yes/no answer. (Binge eating)	Sexual and physical victimization was associated with binge eating. Physical revictimization was associated with higher odds of obesity ($OR = 2.38$, *95% CI*: 1.38–4.10). Women who experienced physical abuse revictimization ($OR = 3.11$, *95% CI:* 1.42–6.80), sexual abuse revictimization ($OR = 2.79$, *95% CI:* 1.24–6.27), or any type of revictimization ($OR = 2.78$, *95% CI:* 1.25–6.15) were more likely to report binge eating than those who reported no abuse in their lifetime.

Table 1 (continued)

Authors (year)	Country	*n*, type of sample and % of women	Type of instrument used for intimate partner violence (type of violence)	Type of instrument used for ED (types of ED/symptoms)	Main results
8. Cha et al. (2016)	USA	9,677 students (51.2%)	A single two ítems adhoc where answer were categorized into the following mutually exclusive groups: 1) physical Dating Violence (DV) only 2) sexual DV only, 3) both physical and Sexual DV 4) no DV	A single three items adhoc about unhealthy weight control behaviors with yes/no answers. (Anorexia nervosa and bulimia nervosa)	Male and female adolescents who reported VPI had increased odds of eating disorder compared to those with no VPI. Notable gender differences were observed such that the relationship between VPI and disordered eating was stronger for males than for females regardless of DV type. Males who reported physical VPI only (*OR* = 1.83, *95% CI:* 1.15–2.91), both physical and sexual DV (*OR* = 2.54, *95% CI:* 1.55–4.16), and any form of DV (*OR* = 2.43, *95% CI:* 1.81–3.25) were significantly more likely to report eating disorder than male adolescents with no DV. No significant differences were observed for males with sexual DV compared to those with no DV experience. Female adolescents who reported both physical and sexual violence were more than twice as likely to report eating disorder compared to those with no DV (*OR* = 2.54, *95% CI* = 1.75–3.69).
9. Claydon et al. (2022)	USA	1,580 university students (61.4%)	Adapted from Conflict Tactic Scale-2 (CTS-2, Straus et al., 1996) (Verbal and physical violence)	SCOFF (Sick, Control, One, Fat, Food; Morgan et al., 1999)	During COVID-19 quarantine, the home becomes a dangerous place for victims of domestic violence. The article highlights the need for domestic violence prevention programs and accurate assessment of multiple domains of abuse during the COVID-19 emergency.
10. Claydon et al. (2024)	USA	1,580 university students (61.4%)	Conflict-Tactics Scale (CTS; Straus, 1979) (verbal and physical violence)	SCOFF Questionnaire (Morgan et al., 1999) (AN and BN)	Perpetuation of intimate partner violence was significantly associated with alcohol use ($\beta = 0.13$, $p < .01$) and alcohol relevance in college life ($\beta = 0.11$, $p < .01$), but not with ED symptoms.
11. Convertino et al. (2021)	USA	217 minority (0%)	HITS screening tool (Hurt-Insult-Threaten- Scream; Sherin et al., 1998), (Physical and psychological violence)	DMS (Drive for Muscularity Scale; McCreary, 2007, Spanish validation Escoto et al., 2013). (Musculatura)	VPI experiences were negatively associated with muscularity-related dissatisfaction.
12. Creech et al. (2021)	USA	442 pregnant veterans (100%)	EHITS (Extended-Hurt/Insult/Threaten/Scream–Modified Version; Portnoy et al., 2018). (nr)	Mental health history was assessed via self-report measure and chart review. (nr)	The IPV group had significantly higher proportions of women reporting eating disorders, compared to the IPV − group.
13. Gezen and Oral (2013)	Turkey	81 women victims of violence (100%)	nr (nr)	SCL-90 (Symptom Check List-90; Derogatis, 1994).	Levels of symptoms related with eating disorders were found high in both groups.
14. Gonçalves et al. (2022)	Portugal	64 ED outpatients (95.3%)	CADRI (Conflict in Adolescent Dating Relationships Inventory; Wolfe et al., 2001) (Physical, sexual and psychological violence)	EDE-Q (Eating Disorder Examination Questionnaire; Machado et al., 2014) (ED symptomtology)	More episodes of dating violence perpetration were associated with a high EDE-Q global score ($r = .46$, $p < .001$) and with high restraint ($r = .49$, $p < .001$), high shape concern ($r = .41$, $p = .002$), and high weight concern ($r = .42$, $p < .001$). No significant correlations were found between DA perpetration and eating concern ($r = .25$, $p = .06$). More episodes of DA victimization were associated with a high EDE-Q global score ($r = .40$, $p = .002$) and with high restraint ($r = .34$, $p = .01$), high eating concern ($r = .26$, $p = .04$), high shape concern ($r = .45$, $p < .001$), and high weight concern ($r = .42$, $p < .001$).

Table 1 (continued)

Authors (year)	Country	*n*, type of sample and % of women	Type of instrument used for intimate partner violence (type of violence)	Type of instrument used for ED (types of ED/symptoms)	Main results
15. Holmes et al. (2023)	USA	212 survivors of intimate partner violence (100%)	CASR-SF (The Composite Abuse Scale Revised-Short Form; Ford-Gilboe et al., 2016). (Physical, sexual and psychological violence)	EDDS (The Eating Disorder Diagnostic Scale; Bohon & Stice, 2015). (Anorexia, bulimia, binge eating, atypical anorexia)	There was a significant total effect of IPV on disordered eating and an indirect effect through PTSD symptoms. IPV was significantly associated with weight/shape concerns and there was an indirect effect through PTSD. There was a significant total effect of IPV on binge symptoms. Higher levels of IPV were associated with greater PTSD symptom severity which was associated with both weight/shape concerns and binge symptoms.
16. Huston et al. (2019)	USA	190 female veteran (100%)	HARK screening tool (Humiliate/Afraid/Rape/Kick; Sohal et al., 2007) (physical, sexual or psychological)	Eating Disorder Diagnostic Scale (EDDS; Stice et al., 2000) (anorexia nervosa, bulimia nervosa and binge eating disorder).	Approximately 14.11% of participants met criteria for any ED (7.83% BN; 6.28% BED), and 49.42% reported lifetime IPV histories. Eating disorder symptoms were significantly associated with lifetime IPV, PTSD symptoms, and depression at the bivariate level. Results from the mediation model revealed that lifetime IPV was indirectly associated with EDDS scores, through PTSD symptoms and depression symptoms.
17. Jonas et al. (2014)	United Kingdom	7,407 general population living in private households (59.7%)	British Crime Survey questions, with positive or negative answer to the questions. (Physical and psychological violence)	SCOFF (Sick-Control-One, Fat-Food; Morgan et al. 1999). (Potential eating disorders)	For lifetime IPV, the association was significant in for eating disorder $OR = 3.2$ (2.0–5.0). When the sample is separated by gender, this association remains significant for women $OR = 3.6$ (2.1–6.1), but not for men 2.0 (0.7–6.6). The ORs were greater for physical than for emotional IPV for eating disorders.
18. Kondo et al. (2023)	Japan	699 university students (34%)	Nationally administered questionnaire on experiences of intimate partner violence.	Nationally administered questionnaire on eating disorder symptoms SCOFF (screening tool for eating disorders) and DEBQ (disordered eating behavior questionnaire).	Women were more likely to experience physical and emotional abuse by their partners and overeating when there is a history of treatment than women without a history of treatment.
19. Kothari et al. (2015)	United Kingdom	G1: 10,041 pregnant women at prenatal stage (100%)	A series of five self-report questionnaires, designed and extensively piloted by ALSPAC, were sent to mothers over the perinatal period and included questions regarding their experience of IPV (Physical and psychological violence)	At 12 weeks gestation, women were sent a questionnaire that included a brief self-report screening for history of psychiatric illness and Eating Disorders Examination Questionnaire (EDE-Q; Peláez-Fernandez et al., 2012). (Anorexia and Bulimia nerviosas)	Prevalence of physical and emotional IPV was higher among women with lifetime eating disorder than those without. In comparison with women without eating disorder women with lifetime eating disorder showed higher odds of reporting physical IPV during the prenatal period ($OR = 2.24$, *95% CI*: 1.09–4.62) and at 8–33 months after delivery ($OR = 2.47$, *95% CI*: 1.40–4.33), but not during the postnatal period. In comparison with women without eating disorder, women with lifetime eating disorder showed higher odds of reporting emotional IPV during the prenatal ($OR = 2.27$, *95% CI*: 1.51–3.43, $p < .001$) and postnatal periods ($OR = 2.38$ *95% CI*: 1.56–3.64, $p < .001$), and at 8–33 months after delivery ($OR = 1.57$, *95% CI*: 1.06–2.33, $p < .02$).

Table 1 (continued)

Authors (year)	Country	*n*, type of sample and % of women	Type of instrument used for intimate partner violence (type of violence)	Type of instrument used for ED (types of ED/symptoms)	Main results
20. Kothari et al. (2015)	United Kingdom	G2: 10,620 newly delivered women (100%)	A series of five self-report questionnaires, designed and extensively piloted by ALSPAC, were sent to mothers over the perinatal period and included questions regarding their experience of IPV. (Physical and psychological violence)	At 12 weeks gestation, women were sent a questionnaire that included a brief self-report screening for history of psychiatric illness and Eating Disorders Examination Questionnaire.	The results of the study indicate that women with eating disorders (ED) are more likely to experience physical and emotional intimate partner violence (IPV) during and after the perinatal period compared to those without ED. The prevalence of IPV was higher among women with lifetime EDs, especially those with marked weight and shape concerns and/or purging during pregnancy. Women with ED and concerns during pregnancy face an increased risk of IPV, highlighting the importance of addressing these conditions comprehensively during perinatal care.
21. Kothari et al. (2015)	United Kingdom	G3: 8,812 newly delivered women 8–33 weeks (100%)	A series of five self-report questionnaires, designed and extensively piloted by ALSPAC, (Physical and psychological violence)	Brief self-report screening for history of psychiatric illness and Eating Disorders Examination Questionnaire.	Women with lifetime ED showed higher prevalence of IPV during and after the perinatal period (physical = 9.6%–14.3% and emotional = 24.1%–28.1%). Lifetime ED was associated with higher odds of physical IPV during the perinatal period (*OR* = 2.34, *95% CI*: 1.11–4.93, $p = .03$). Lifetime ED with and without pregnancy shape and weight concerns and/or purging was associated with higher odds of IPV after the perinatal period, and higher odds of reporting emotional IPV at all time points. Associations were moderated by partner's response to pregnancy and maternal experience of childhood sexual abuse.
22. Lacey and Mouzon (2016)	USA	949 women victims of violence (100%)	A single item adhoc with yes/no answer (Physical violence)	WMH-CIDI (World Mental Health (WMH) SurveyInitiative Version of the World HealthOrganization (WHO) CompositeInternational Diagnostic Interview (CIDI), Kessler & Üstün 2004).	Rates of eating disorders were generally higher for those with a history of IPV than those without such a history. More than a twofold difference was found between the two groups for bulimia (7.9% vs. 2.8%, $p < .05$) and more than a threefold difference in rates of binge eating was also detected (19.5% vs. 6.1%, $p < .05$).
23. Lacey et al. (2015a, 2015b)	USA	3,277 Black women of African and African-American origin (100%)	A single item adhoc with yes/no answer (Physical violence).	A modified version of the WHO CIDI (WHO Composite International Diagnostic Interview).	The control variables (age, family income and educational level) did not significantly predict acceptance of intimate partner violence. When adding anxiety, aggressiveness, and collectivism, the variance explained increased significantly Aggressiveness increased the acceptance of violence ($\beta = 0.62$), whereas collectivism reduced it ($\beta = -0.21$). Anxiety was not significant. Acceptance of violence was not related to age, but was negatively related to income and educational level. Aggressiveness showed a strong positive relationship with violence acceptance ($\beta = 0.45$), and anxiety a weak positive relationship ($\beta = 0.15$). Collectivism was negatively associated with the acceptance of violence.
24. Lacey et al. (2015a, 2015b)	USA	6,082 general population (100%)	A simple item adhoc (Physical violence)	World Health Organization Composite International Diagnostic Interview (DSM-IV) (Anorexia nerviosa, bulimia nerviosa y trastorno por atracón)	Abused women were vulnerable to eating disorders (bulimia and binge eating).

Table 1 (continued)

Authors (year)	Country	*n*, type of sample and % of women	Type of instrument used for intimate partner violence (type of violence)	Type of instrument used for ED (types of ED/symptoms)	Main results
25. Lebed et al. (2023)	USA	14,322 (49.2%)	Intimate partner violence (IPV): Physical or sexual abuse in romantic relationships (0 = no, 1 = yes) (physical, emotional and sexual abuse)	Eating disordered behaviors: Eating preoccupations and compensatory behaviors (0 = no, 1 = yes)	The study found a robust association between childhood maltreatment and eating disorders in adults, as well as between intimate partner violence and eating disorders in adults. In addition, those who experienced multiple forms of childhood maltreatment or intimate partner violence were found to be at increased risk for developing disordered eating behaviors in adulthood. Only 16.70% of students reported two or more items on SCOFF, suggesting possible ED. SA and IPV were positively associated with ED.
26. Lucea et al. (2012)	USA	790 women victims of violence (100%)	ASS (The Abuse Assessment Screen; McFarlane et al., 1992) and WEB (Women's Experiences of Abuse; Smith et al., 1995). (Physical, sexual and psychological violence)	A single item adhoc where if they answer "many times" and "everyday/almost every day" were considered positive for Eating Disorder. (Eating Disorder)	The physical, sexual and psychological violence were significantly associated with eating disorder. Abused women were significantly more likely to report disordered eating. Increasing severity of physical and sexual violence both conferred additional risk for disordered eating. Those women with moderate and severe risk for lethality from IPV were nearly 4.5 and 9 times more likely to report disordered eating in the past year, respectively, compared to women at no risk for lethality in unadjusted analysis (*OR* = 4.48, *95% CI*: 1.03–19.36; *OR* = 8.98, *95% CI*: 2.04–39.42).
27. Mattar et al. (2022)	Lebanon	367 women over 18 years of age (100%)	Violence exposure assessment questionnaire (divided into psychological, physical, sexual and economic abuse)	SCOFF Questionnaire (Morgan et al., 1999)	Scores for total violence and all its subscales were significantly higher in the exposed group (EG) compared to the unexposed group (UG). 77.78% of participants in the EG were more likely to be at risk for eating disorders according to the SCOFF tool compared to the UG. In addition, total violence, physical violence, and sexual violence were associated with increased risk of eating disorders. Only the external eating score was significantly higher in the EG compared to the UG.
28. McCall-Hosenfeld et al. (2015)	USA	302 Women victims of violence (100%)	HARK (Humiliation–Afraid–Rape–Kick screener; Sohal et al., 2007). (Physical and psychological violence)	ESP (The Eating Disorder Screen for Primary Care; Cotton et al., 2003). (Dieting and bulimia)	Among 302 women with lifetime history of IPV, 41 were at high risk, 127 were at moderate risk, and 134 were at low risk of an eating disorders according to the ESP.
29. McGee and Thompson (2013)	USA	3,161 adolescent boys (0%)	nr (sexual violence)	Youth Risk Behavior Survey (Dines et al., 2010) (specific eating-related behaviors, such as fasting, use of diet pills without medical advice, and vomiting or use of laxatives for weight loss)	Adolescent boys who reported experiences of forced sexual intercourse were 2.50 times more likely to report disordered eating behaviors.
30. Mitchison et al. (2016)	Australia	19 Clinical sample (100%)	nr (nr)	EDE-Q (The Eating Disorder Examination Questionnaire; Peláez-Fernandez et al., 2012).	Abusive intimate partner relationship as a vulnerability factor to develop weight-related teasing from partner leading to eating disorder symptoms; coping with neglect from partner through binge eating and coping with over-controlling partner through restriction.

Table 1 (continued)

Authors (year)	Country	*n*, type of sample and % of women	Type of instrument used for intimate partner violence (type of violence)	Type of instrument used for ED (types of ED/symptoms)	Main results
31. Momeñe et al. (2022)	Spain	683 general population (78%)	VREPS (The Violence Received, Exercised and Perceived in Youth and Adolescent Dating Relationships Scale; Urbiola et al., 2020) (Physical, sexual, psychological and social violence)	EDI-2 (The Eating Disorders Inventory-2; Garner, 1988) (Obsession with thinness, bulimia, body dissatisfaction)	Some of the EDCs were not significantly correlated with any of the received violence indicators (i.e., bulimia, body dissatisfaction).
32. Momeñe-Lopez et al. (2020)	Spain	712 university students and gym-goers (76.5%)	RCTS-2 (Revised scale of conflict resolution tactics; Straus et al., 1996) (Physical, sexual and psychological violence)	EDI-2 (Eating Disorders Inventory; Garner, 1988) and MULTICAGE CAD-4 (Pedrero-Pérez et al., 2007) (Obsession with thinness, Bulimia and body dissatisfaction)	Physical and psychological violence were positively associated with bulimia (r=.11; r=.08 and r=.09, respectively), but not with drive for thinness (r=.06; r=.04 and r=.04, respectively) and body dissatisfaction (r=.07; r=.04 and r=.05, respectively). Sexual coercion did not show a significant relationship with any of the three variables: obsession with thinness (r=.06), bulimia (r=.06) and body dissatisfaction (r=.03). Likewise, all types of emotional dependence on the aggressor partner together with violence received are positively related to the three dimensions of the EDI.
33. Muyan et al. (2015)	Turkey	170 students (100%)	HITS (Hurts, Insults, Threatens, and Screams Scale; Sherin et al., 1998). (Physical and psychological violence)	EAT (Eating Attitudes Test; Garner & Garfinkel, 1979). (Dieting and bulimia)	IPV victimization and several of the perfectionism dimensions were positively associated with dieting and/or bulimia. IPV predict dieting (β=.22) and bulimia (β=.16)
34. Romito et al. (2013)	Italy	586 High-school students (55,8%)	Nine items regarding abusive behavior by a partner or an ex-partner.	Students were asked how often they eat without being able to stop, eat until they feel sick, self-induce vomiting, use laxatives or diuretics, and monitor their weight.	Female students who had experienced IPV have significantly higher risk for mild eating problems (OR = 1.9). Male students who experienced IPV have significantly higher risk for eating problems (OR = 1.83).
35. Skomorovsky et al. (2006)	Canada	83 students (100%)	R-CTS (The Conflict Tactics Scale Revised; Straus et al., 1996). (Physical, psychological and sexual violence)	EAT-26 (The 26-item Eating Attitudes Test; Garner et al., 1982). (Dieting and bulimia)	Disturbed eating patterns were more evident in the presence of physical abuse, and were related to reports of greater psychological aggression. Only psychological aggression was found to be uniquely predictive of greater dieting, β = 0.37, p <.01, and bulimic symptoms, β = 0.35, p <.01.
36. Svavarsdottir and Orlygsdottir (2009)	Iceland	2,746 general population (100%)	WAST (The Woman Abuse Screening Tool; Brown et al. 2000).	28-item questionnaire generated by investigators (Svavarsdottir & Orlygsdottir, 2006).	Among both married and cohabiting women the degree of abuse differed based on the presence of eating disorders (married t = -3.59, d.f. = 85.57, p =.001; cohabiting t = -2.09, d.f. = 36.33, p =.044). Thus, married and cohabiting women who smoked, and had eating disorders reported higher levels of abuse compared with those who did not engage in these health risk behaviors or have chronic health problems.
37. White et al. (2018)	USA	9 ED out-patients (100%)	A single item adhoc with yes/no answer.	DSM-IV-TR criteria.	Patients who were exposed to domestic violence reported a significantly higher EBW (M = 104.2; SD = 19.6; t(180) = -2.04, p =.043) than their counterparts.

Table 1 (continued)

Authors (year)	Country	*n*, type of sample and % of women	Type of instrument used for intimate partner violence (type of violence)	Type of instrument used for ED (types of ED/symptoms)	Main results
38. Wong y Chang (2016)	USA	25 general and clinical population (100%)	Focus groups and individual interviews. (Physical, sexual and psychological violence).	Focus groups and individual interviews.	Analysis of transcripts identified several dominant themes describing the influence of IPV on the evolution of victims' altered eating behaviors. Most women described their partners' controlling behavior to be pervasive and included restricting their food intake, the kinds of foods they could eat, and the amount of money that could be used to purchase food. When women tried to eat healthily, their attempts were ridiculed by their partners. Women expressed feeling numb from the abuse and used food as a stimulant or to lift their spirits. Food also served the purpose of filling an emotional emptiness. In the absence of their partners' and other social support, a few women regarded food as a source of comfort. Many of the women who repeatedly returned to food to cope discussed difficulties with over-eating and weight gain. For some women, food and eating were also used as forms of self-abuse. Abusers' insults, particularly about victims' body and appearance, injured victims' self-esteem and self-image. These women had used food to make themselves as unattractive as their abusers made them feel.
39. Yoon et al. (2022)	USA	1,568 students (54%)	A single items adhoc with yes/no answer: (Physical, psychological and sexual violence)	A single items adhoc with yes/no answer: (Binge eating, overeating and intuitive eating)	In women intimate partner sexual violence was most strongly associated with overeating (*PR* = 2.1; 95% *CI*: 1.4–3.1). Among women, intimate partner sexual violence was most strongly associated with binge eating (*PR* = 2.4; 95% *CI:* 1.5–3.9). There is an association between the number of exposures to IPV with binge eating. Among men, intimate partner physical violence was most strongly associated with less intuitive eating ($\beta = 0.6$; 95% *CI:* -0.9, -0.2). Among women, intimate partner sexual violence was most strongly associated with less mindful eating ($\beta = -0.6$; *95% CI:*–0.8, -0.3).
40. Yoon et al. (2021)	USA	408 students (34.9%)	Verbatim questions assessing abuse on the EAT 2018 survey (Physical and sexual violence)	Two items adapted from Questionnaire on Eating and Weight Patterns-Revised (Yanovski et al., 2015) and Minnesota Adolescent Health Survey (Blum et al., 1989). (nr)	Among perpetrators, sexual abuse perpetrated by intimate partners was most strongly associated with binge eating (*RR* = 2.41. *95% CI:* = 1.70–3.41). Physical abuse perpetrated by intimate partners was strongly associated with binge eating (*RR* = 1.95. *95% CI:* 1.35–2.81).

[1]In this study, gender was registered as either female, male or transgender

were 2.5 times more likely to develop ED (*OR* = 2.5, 95% *CI:* 1.6–3.9) compared to those who had not experienced IPV; as observed by Wong and Chang (2016) in their study. They consistently observed that IPV victims are three times more likely to report disordered eating behavior, such as binge eating and self-induced vomiting (15.7% vs. 5.4% in non-victims).

Regarding the severity of the relationship between IPV and ED, Lacey et al. (2015a, 2015b) found that lifetime IPV is associated with higher scores on the ED (*OR* = 2.46, 95% *CI*: 1.23–3.51), indicating greater severity of ED symptoms. On the other hand, Gonçalves et al. (2022) found that a greater number of episodes of dating violence perpetration and victimization is associated with higher scores on the EDE-Q scale ($\beta = 0.45$, $p < 0.01$), dietary restraint ($\beta = 0.38$, $p < 0.05$) and body shape concerns ($\beta = 0.42$, $p < 0.01$). Likewise, Muyan et al. (2015) highlight that IPV victimization was a significant predictor of both dieting and bulimia ($\beta = 0.22$, $p < 0.01$ and $\beta = 0.16$, $p < 0.05$, respectively). This was corroborated by Brewer and Thomas (2019) demonstrating that IPV survivors were more likely to report disordered eating compared to their non-maltreated peers ($r = -0.36$, $p < 0.001$). Similarly, McCall-Hosenfeld et al. (2015) stated that among women with a history of IPV, 14%

were identified as being at high risk for ED. White et al. (2018) reported that patients exposed to IPV reported significantly higher Excess Body Weight (%EBW) ED symptomatology ($M = 104.2$, $SD = 19.6$; t (180) = -2.04, $p = 0.04$). To conclude, Lacey and Mouzon (2016) stated that ED rates are higher in those with a IPV history than in those without such a history (19.5% vs. 6.1%, $p < 0.05$), with a notable difference between both groups for BN (7.9% vs. 2.8%, $p < 0.05$) and BED (19.5% vs. 6.1%, $p < 0.05$).

Relationship between IPV and ED by gender

Creech et al. (2021) found that women who reported IPV in the past year had a significantly higher rate of ED ($p = 0.00$) than men, indicating a strong association between IPV and ED. In addition, they reported significantly higher rates of depression ($p = 0.01$) and PTSD ($p = 0.02$).

On the one hand, Wong and Chang (2016) found about 10–15% of women experienced food control by their partner, and 25% used food as a coping mechanism. In addition, women who experienced IPV are more than five times more likely to be diagnosed with anorexia or bulimia nervosa compared to those who did not experience IPV (*OR* = 5.2; 95% *CI*: 2.8–9.8).

Bartlett et al. (2018) found that physical, sexual, and psychological victimization were significantly associated with ED, with increased risk among battered women ($\beta = 0.14$, $p = 0.04$; $\beta = 0.22$, $p < 0.001$; $\beta = 0.22$, $p < 0.001$, respectively). In addition, each type of IPV in the past year was significantly associated with symptoms of disordered eating patterns in men: physical victimization ($\beta = 0.15$, $p < 0.001$), sexual victimization ($\beta = 0.12$, $p < 0.001$), and fear of partner ($\beta = 0.24$, $p < 0.001$). In women, several types of IPV were associated with higher scores on the EDS instrument: physical victimization in the past year ($\beta = 13.74$, $p < 0.01$), sexual victimization ($\beta = 15.37$, $p < 0.001$), severe psychological victimization ($\beta = 14.68$, $p < 0.001$), and "any IPV" ($\beta = 10.54$, $p < 0.001$).

However, Cha et al. (2016) revealed that both male and female adolescents reporting IPV had higher odds of ED, with the relationship being stronger for males, regardless of the type of violence. For physical violence alone, males had a higher odds of ED (*OR* = 1.91, 95% *CI*: 1.10–3.33), while females had a high but lower odds (*OR* = 1.44, 95% *CI*: 1.10–1.90). For sexual violence, males also showed an increased likelihood of ED (*OR* = 1.70, 95% *CI*: 0.89–3.23), and females had a similar, although not as significant, likelihood (*OR* = 1.26, 95% *CI*: 0.96–1.65). For physical and sexual violence combined, males showed a significantly increased risk of ED (*OR* = 2.52, 95% *CI:* 1.45–4.39), and females also showed an elevated risk (*OR* = 2.35, 95% *CI*: 1.60–3.46). For any form of IPV (physical and/or sexual), males had a significantly increased likelihood of ED (*OR* = 2.01, 95% *CI*: 1.44–2.79), and females also showed an increased risk (*OR* of 1.57, 95% *CI*: 1.31–1.88).

Yoon et al. (2022) found that sexual violence perpetrated by a partner was more strongly related to overeating and binge eating among women (Risk Prevalence = 2.1, 95% *CI*: 1.4–3.1). Ackard and Neumark-Sztainer (2002) found that girls who experienced dating violence and rape were 5.76 times more likely to use laxatives (*OR* = 5.76, 95% *CI*: 5.53–5.99), 5.08 times more likely to use diet pills (*OR* = 5.08, 95% *CI*: 4.95–5.21), 4.74 times more likely to vomit (*OR* = 4.74, 95% *CI:* 4.60–4.88), 2.22 times more likely to fast or skip meals (*OR* = 2.22, 95% *CI*: 2.10–2.34) and 2.15 times more likely to binge eat (*OR* = 2.15, 95%: 1.99–2.31) than men. McGee and Thompson (2013) found that 12.6% of males who reported forced sexual intercourse experiences were more likely to exhibit disordered eating behavior. In bivariate analysis, males who reported forced sexual intercourse were 3.40 times more likely to have disordered eating behavior (*OR* = 3.40, 95% *CI*: 2.40–4.81) compared to those who did not report it.

Regarding physical violence, according to the study by Yoon et al. (2022) among men intimate partner physical violence was more associated with less intuitive and/or disordered eating (β =—0.6, 95% *CI* = -0.9–0.2). Bonomi et al. (2013) observed that women who experienced physical/sexual dating violence victimization had a higher risk of fasting for more than 24 h to lose weight (Prevalence Ratio [PR] = 4.71, 95% *CI*: 2.12–10.5), use of dietary aids to lose weight (PR = 1.98, 95% *CI*: 1.17–3.36) and vomiting to lose weight (PR = 4.33, 95% *CI*: 2.66–7.03).

Finally, Kondo et al. (2023) found that women with ED had significantly higher rates of childhood traumatic experiences and IPV compared to men. In addition, many of these women were in treatment for substance use. Specifically, history of treatment for substance use disorder was significantly higher in women (42.4%) than in men (15.8%) ($\chi^2(1) = 41.22$, $p < 0.001$).

Types of violence and ED

White et al. (2018) corroborated that patients exposed to physical violence reported ED symptomatology compared to patients who did not experience violence ($M = 104.2$, $SD = 19.6$; t (180) = -2.04, $p = 0.04$). Regarding sexual violence, Yoon et al. (2021, 2022) found that intimate partner-perpetrated sexual violence is associated with overeating and binge eating among women (*PR* = 2.1, 95% 1.4–3.1) and an increased risk of binge eating (*PR* = 2.41, 95% *IC* 1.70–3.41). In addition, Caceres et al. (2021) found that combined physical and sexual victimization is associated

with an increased risk of binge eating (*OR* = 2.5; 95% *CI*: 1.7–3.7) and obesity (*OR* = 1.8; 95% *CI*: 1.2–2.6).

Regarding psychological violence, Lacey et al. (2015a, 2015b) added that psychological aggression was shown to be a significant predictor of ED ($\beta = 0.37$, $p < 0.01$). A study conducted by Momeñe-López et al. (2020) showed that psychological violence received was significantly associated with body dissatisfaction ($\beta = 0.18$, $p < 0.01$) and bulimic symptoms ($\beta = 0.35$, $p < 0.01$). Likewise, Convertino et al. (2021) underline that psychological violence correlates positively with muscle-oriented behavior ($r = 0.54$, $p < 0.001$). Finally, Skomorovsky et al. (2006) found that psychological aggression was related to health-threatening dieting behavior ($\beta = 0.37$, $p < 0.01$) and bulimic symptoms ($\beta = 0.35$, $p < 0.01$).

Mediating and moderating variables in the relationship between IPV and EDs

Holmes et al. (2023) demonstrated that PTSD symptoms act as significant mediators in the relationship between IPV and EDs. Spefically, a significant total effect of IPV on ED symptomatology was found ($\beta = 0.19$, $p = 0.002$, *ER* = 0.07, 95% *CI*: 0.06—0.32), as well as a significant indirect effect through PTSD symptoms ($\beta = 0.15$, $p = 0.001$, ER = 0.05, 95% *CI*: 0.06—0.27). Huston et al. (2019) and Lacey et al. (2015a, 2015b) found that lifetime IPV is indirectly associated with higher scores on the ED diagnostic scale across PTSD and depression symptoms, with significant indirect effects (95% *CI*: 0.87–3.58 for PTSD and 0.40–3.59 for depression).

For weight and body shape concerns, IPV had a significant total effect ($\beta = 0.05$, $p = 0.02$, *SE* = 0.02, *95% CI*: 0.00–0.09), and an indirect effect through PTSD symptoms ($\beta = 0.05$, $p = 0.00$, *SE* = 0.02, *95% CI*: 0.02–0.08). For binge eating symptoms, IPV also showed a significant total effect ($\beta = 0.05$, $p = 0.003$, *SE* = 0.02, 95% *CI*: 0.01–0.10) and an indirect effect across PTSD symptoms ($\beta = 0.05$, $p = 0.00$, *SE* = 0.02, 95% *CI*: 0.02–0.08). When analysing PTSD-specific symptoms, negative alterations in cognition and mood emerge as the only significant mediators between IPV and concerns about body weight and shape ($\beta = 0.06$, $p = 0.01$, *SE* = 0.02, 95% *CI*: 0.02–0.10).

On the other hand, in the study by Momeñe et al. (2022) it was observed that people with high scores in ED had a higher risk of developing emotional dependence and of remaining in violent relationships. The emotional dependence variable moderated the relationship between ED and physical violence ($\beta = 0.15$, $p < 0.001$), psychological violence of humiliation-coercion ($\beta = 0.11$, $p = 0.02$) and social violence received ($\beta = 0.12$, $p = 0.002$). Higher fear of loneliness was significantly related to more physical ($\beta = 0.16$, $p < 0.001$) and psychological humiliation-coercion ($\beta = 0.11$, $p = 0.02$) violence when social withdrawal was high. Regarding received social violence, fear of loneliness was related to less violence when social withdrawal was low ($\beta = -0.19$, $p = 0.04$) and to more violence when social withdrawal was high ($\beta = 0.13$, $p = 0.002$).

Regarding other possible variables that mediate or explain the relationship between IPV and ED is a study by Claydon et al. (2024) who found that IPV was significantly associated with alcohol use ($\beta = 0.13$, $p < 0.01$). Approximately 16.7% of the participants presented symptoms of EDs according to the SCOFF questionnaire, and 28.4% indicated having perpetrated some type of IPV. On the other hand, Svavarsdottir and Orlygsdottir (2009) stated that married or cohabiting women who smoked and suffered from ED reported higher levels of abuse compared to those who did not engage in health risk behavior or did not have chronic health problems (married: t = 3.59, l.g. = 85.57, $p = 0.001$; cohabiting: t = 2.09, l.g. = 36.33, $p = 0.04$).

Ackard et al. (2003) found that adolescents from lower socioeconomic backgrounds were more likely to report dating violence. This was associated with dieting behavior ($\beta = 0.15$, $p < 0.001$), binge eating and purging behavior ($\beta = 0.12$, $p < 0.001$), cigarette smoking ($\beta = 0.18$, $p < 0.001$), alcohol use ($\beta = 0.20$, $p < 0.001$), drug use ($\beta = 0.22$, $p < 0.001$), suicidal thoughts ($\beta = 0.25$, $p < 0.001$), depression ($\beta = 0.30$, $p < 0.001$), and lower self-esteem ($\beta = -0.28$, $p < 0.001$) for both genders. Other possible mediating variables that Momeñe et al. (2022) found that inefficacy ($\beta = 2.81$, $p = 0.005$), fear of maturity ($\beta = 2.61$, $p = 0.009$) and impulsivity ($\beta = 2.66$, $p = 0.008$) had significant indirect effects on physical and social violence received through fear of loneliness, but only at high levels of social withdrawal ($\beta = 2.\ 34$, $p = 0.019$ and $\beta = 2.25$, $p = 0.024$, respectively).This indicates that there is indeed a moderate relationship with factors such as fear of loneliness and high social withdrawal.

As for other behaviors, Yoon et al. (2021) found that relationship abuse is more strongly associated with binge eating than with overeating. Risk factors include sexual abuse by family members as mediators of this relationship (*PR* = 1.48, 95% *CI*: 1.01–2.17 for compulsive eating) and sexual abuse by intimate partners (*PR* = 2.41, *95% CI*: 1.70–3.41 for compulsive eating), as well as physical abuse by family members (*PR* = 1.84, 95% *CI*: 1.33–2.53 for compulsive eating) and by intimate partners (*PR* = 1.95, 95% *CI*: 1.35–2.81 for compulsive eating).

Lebed et al. (2023) revealed a strong association between childhood maltreatment, IPV, and adult EDs, showing that those who experienced multiple forms of childhood maltreatment or IPV were at increased risk for developing disordered eating behavior in adulthood. Specifically, they

found that childhood maltreatment was associated with an increased risk of ED in adulthood ($\beta = 0.25$, $p < 0.001$). IPV was also significantly associated with EDs ($\beta = 0.30$, $p < 0.001$) and the combination of childhood maltreatment and IPV was positive ($\beta = 0.45$, $p < 0.001$). Thus, the results show that both childhood maltreatment and IPV are important predictors of EDs in adulthood, and their combination further increases this risk.

Discussion

The relationship between IPV and ED is a complex and multidimensional topic that has been the subject of considerable research in recent years. The reviewed studies show a significant association between IPV, including physical, psychological, and sexual violence, and various diagnoses of EDs such as AN, BN, and BED (e.g., White et al., 2018; Yoon et al., 2021). Regarding the directionality in the relationship between the variables under study, the vast majority of the studies analysed lead us to the conclusion that being immersed in an abusive relationship leads to a series of consequences on the mental health of the individual (e.g., Creech et al., 2021; Gonçalves et al., 2022; Huston et al., 2019). Thus, the consequences of being subjected to violence by a partner leads to a series of symptoms and the genesis of psychopathology, among which we can highlight EDs (e.g., Creech et al., 2021; Lacey et al., 2015a, 2015b). This relationship could be responding to strategies and behaviors that are deployed in people with an EDs and which would serve as escape and coping mechanisms for situations of suffering such as being a victim of IPV (Moulding, 2015).

However, it is also possible that EDs could be the prelude to IPV. In fact, certain characteristics of some of the EDs, such as BN are impulsivity, emotional dysregulation or low self-esteem, among others (Howard et al., 2020; Jones et al., 2022; Prefit et al., 2019). As has been observed by some researchers specialized in analysing risk factors for IPV, impulsivity has been associated to a greater extent in those individuals who perpetrate violence (Mannarini et al., 2023), being therefore this characteristic something to take into account also in those people who suffer from certain EDs. All these characteristics could be exacerbated in situations of conflict in a relationship, which in turn could be exacerbated in situations of conflict in a relationship.

Influence of gender

In the systematic review conducted, there was a tendency to focus on women when studying the effects of IPV on ED (Sepulveda et al., 2004). Although it is crucial to understand the impact of IPV on women, it is equally important to recognize and address the experiences of men, who are also victims of IPV and may develop EDs as a result (Gonzales Cueva & Silvera Chavez Arroyo, 2022). However, this disparity leaves a significant gap in our understanding of how men experience and manage both IPV and EDs, perpetuating myths and stigmas that prevent men from receiving adequate support (Calvete, 2008). Likewise, men may face additional barriers to seeking help due to social norms and stigmas related to male victimization and EDs (Bomben et al., 2021). Therefore, it is critical to promote inclusive studies that examine IPV and EDs in men, using methodologies that recognize gender differences in the experience and expression of these problems.

The association between IPV and EDs is not uniform and is influenced by a number of factors, such as gender, severity of violence, and other individual contexts and experiences that still require further exploration. IPV affects men and women differently in relation to EDs. For example, Yoon et al. (2022) found that sexual violence perpetrated by a partner is more related to overeating and binge eating among women, whereas physical violence toward a partner in men is more associated with less intuitive and/or disordered eating. These findings lead us to raise the possibility that binge eating acts as a protective mechanism against possible future sexual aggression in samples of women. Thus, binge eating would serve to appear less attractive and, therefore, decrease unwanted attention and the likelihood of future sexual violence (Moulding, 2015).

Severity and nature of violence

IPV has negative effects on the mental health of individuals. A recent study published in 2024 found that higher levels of IPV as well as the severity of different types of intimate partner violence were associated with worse mental health (White et al., 2024). Specifically, these authors found that the severity of physical and psychological violence were associated with depression, anxiety, posttraumatic stress symptoms, psychological distress, alcohol and drug uses and suicidal ideas and behavior. Therefore, being a victim of intimate partner violence can affect the mental health of individuals, affecting coping tools and emotional regulation, EDs can also be the expression of a maladaptive way of coping with such problems (Lacey et al., 2015a, 2015b; Matheson et al., 2015).

Specifically, with regard to the relationship between the IPV and the EDs, the severity and nature of violence influence the relationship with the appearance of EDs (e.g., Bartlett et al., 2018). Studies have found that the more severe the physical or sexual violence, the greater the risk of developing EDs (Lucea et al., 2012). Trauma associated with IPV can trigger or exacerbate EDs, especially when experienced

repeatedly or prolonged (Lebed et al., 2023; Lucea et al., 2012). These data underscore the need to implement preventive IPV screening methods to reduce harmful physical and mental health consequences (Johnson, 2006).

If we consider the relationship between IPV and EDs, we note that in between there may be other factors or symptomatology that may explain this relationship more comprehensively. In addition to violence, factors such as perfectionism, childhood trauma, and substance abuse act as mediators in this relationship. Muyan et al. (2015) found that several dimensions of perfectionism were associated with dieting and/or binge eating. Weight-related teasing by a partner can lead to increased body dissatisfaction and trigger restrictive ED symptoms. Coping with abandonment or loss of a significant relationship can result in binge eating and purgative behavior characteristic of BN (Canals & Val, 2022). The relationship between IPV and ED points to how trauma and stress affect mental health and eating behavior, with eating acting as a coping mechanism to manage stress and perceived control over one's life.

The importance of diagnosis and effective assessment

In several studies reviewed, validated questionnaires were used to assess for the presence of ED and IPV. Although useful and accessible, these questionnaires may limit in-depth understanding of these complex conditions, as they do not fully capture the individual experience, especially in contexts of trauma and abuse (Briere, 1997). There is a risk of self-report bias, where individuals may underestimate or overestimate their experiences due to shame, stigma, or lack of self-awareness. In addition, standardized questionnaires may not be sensitive to cultural, gender, or contextual particularities, limiting diagnostic accuracy (Noyes et al., 2019). To improve the accuracy and efficacy of diagnosis and intervention, it is crucial to incorporate a variety of assessment tools and methods. For example, questionnaires could be complemented by structured clinical interviews that allow for a more in-depth and personalized exploration of IPV and ED experiences (Valdez-Santiago et al., 2006). Adopting a comprehensive, evidence-based approach to assessment and diagnosis will help provide a more complete understanding of individual needs, allowing for more targeted and effective interventions, minimizing misdiagnosis or incomplete diagnoses, and providing more accurate data for research, contributing to better practices in therapeutic intervention.

Limitations

There are limitations in the reviewed studies. First, publication bias and reliance on self-reporting may introduce biases due to underestimation or overestimation of experiences of violence and disordered eating behavior (Cárdenas et al., 2023). Secondly, the selected studies cover a fairly wide range of years; specifically, from 1989 to 2024. Considering the diagnostic criteria for mental disorders such as those being analysed in the present study, it should be noted that during these years the versions of the diagnostic manuals for mental disorders, such as the ICD and DSM, have been modified. Likewise, intimate partner violence is a constantly changing construct that is being shaped and nuanced based on the passage of time and new policies against violence against women and domestic violence. Therefore, it should be borne in mind that the constructs studied and analysed in the studies of the current systematic review may have slight variations. Thirdly, it is important to note the absence of explicit coding of transgender people in most of the studies, a fact that does not imply that there are no transgender women and men in these samples. One aspect to note is that the formulation of questions does not distinguish between cisgender and transgender. This may have led to a simplification where the complexities of gender identity have not been recognized, limiting the visibility and representation of transgender people in these studies.

Finally, the heterogeneity of studies and lack of longitudinal research are also significant limitations. Future studies should focus on inclusive and longitudinal methodologies to better understand the causal relationships and temporal factors in this relationship.

Conclusion and future directions

This work contributes significantly to the understanding of the complex relationship between IPV and EDs, highlighting the need for more inclusive and personalized approaches to research and treatment. Recognizing and addressing these differences is crucial to developing effective strategies to promote mental health across the population. Likewise, the importance of advocating for the proper collection of gender-related information is now crucial for both research and the development of prevention and treatment programs. Indeed, transgender people, especially non-binary people, face increased risks of mental health problems, discrimination, and violence, including elevated rates of EDs, anxiety, and suicide (Lefevor et al., 2019). The findings highlight the importance of personalizing interventions and underscore the urgency for mental health polies and programs that address both IPV and EDs in a comprehensive manner,

promoting a holistic approach that can significantly improve the quality of life of affected individuals.

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Declarations

Conflict of interest The authors have no conflicts of interest to declare.

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