Article

Altered Eating Behaviors in Female Victims of Intimate Partner Violence

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Susan P. Y. Wong, MD[1] and Judy C. Chang, MD, MPH[2]

Abstract

Little is known about altered eating behaviors that are associated with the experience of intimate partner violence (IPV) victimization. Our aim was to explore the experiences and perspectives of IPV victims regarding their eating behaviors and their attitudes toward and use of food. We conducted focus groups and individual interviews with 25 IPV victims identified at a domestic violence agency and asked them about their eating behaviors and how, if at all, these behaviors related to their experience of IPV. Qualitative analysis of the transcribed encounters identified themes explicating the relationship between their eating behaviors and experiences of IPV. All women described altered eating behaviors related to IPV that were categorized into several major themes: (a) somatization (victims experience significant somatic symptoms as a result of abuse); (b) avoiding abuse (victims modify their eating behaviors to avoid abuse); (c) coping (victims use food to handle the psychological effects of abuse); (d) self-harm (victims use food to hurt themselves as a reaction to the abuse); and (e) challenging abusive partners

[1]Department of Medicine, University of Washington, Seattle, WA, USA
[2]Departments of Obstetrics, Gynecology and Reproductive Sciences and Internal Medicine, Magee-Women's Hospital of UPMC, Magee-Womens Research Institute, University of Pittsburgh, Pittsburgh, PA, USA

Corresponding Author:
Judy C. Chang, Departments of Gynecology, Obstetrics and Reproductive Sciences and Medicine, Magee-Women's Hospital of UPMC, 300 Halket Street, Pittsburgh, PA 15213, USA.
Email: jchang@mail.magee.edu

(victims use their eating behaviors to retaliate against their abusers). IPV can provoke altered eating behaviors in victims that may be harmful, comforting, or a source of strength in their abusive relationships. Understanding the complex relationship between IPV and victims' altered eating behaviors is important in promoting healthy eating among victims.

Keywords
domestic violence, spouse abuse, battered women, eating disorder, qualitative research

Introduction

Intimate partner violence (IPV) is associated with significant physical and psychological sequela (Breiding, Black, & Ryan, 2008; Campbell et al., 2002; Coker, Smith, Bethea, King, & McKeown, 2000; Golding, 1999; Kernic, Wolf, & Holt, 2000; McCauley et al., 1995) including disordered eating behaviors (Danielson, Moffitt, Caspi, & Silva, 1998). In one of the first studies examining the various physical and mental health effects of IPV among female primary care patients, McCauley and colleagues noted that binge eating and self-induced vomiting were 3 times more prevalent among victims of IPV as compared with non-victims (15.7% vs. 5.4%; McCauley et al., 1995). Another study examining associations between IPV and *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed., rev.; *DSM-III-R*; American Psychiatric Association, 1987) within a longitudinal birth cohort noted that women who experienced IPV had over 5 times the odds of a diagnosis of anorexia nervosa or bulimia nervosa (Danielson et al., 1998). Surveys of high school and college students also noted that girls or young women who experienced dating violence were more likely than non-victims to eat without being able to stop, vomit to lose weight, fast or skip meals, use diet pills, or take laxatives (Ackard, 2002; Bonomi, 2013; Romito, 2007). Other studies examining the prevalence of IPV among people with eating disorders noted that up to 45% of women with bulimia, 19% with anorexia, and 19% with binge eating disorders reported lifetime physical or sexual IPV experiences (Bundock, 2013; Kaner, 1993; Mitchell, 2012; Piran, 2006; Root, 1988).

Eating disorders, particularly anorexia nervosa, carry a high mortality rate (Arcelus, Mitchell, Wales, & Nielsen, 2011; Harris & Barraclough, 1998; Smink, van Hoeken, & Hoek, 2012) and are particularly difficult to treat, with half of the patients experiencing relapse or recurrence throughout their lives (Carter, Blackmore, Sutandar-Pinnock, & Woodside, 2004; Keel & Mitchell,

1997; Steinhausen, 2002). For patients who have altered eating behaviors that do not fall clearly within the clinical definition of an eating disorder, their prognosis is equally guarded: One fourth of these patients do not attain resolution of their altered eating behaviors (Agras, Crow, Mitchell, Halmi, & Bryson, 2009; Keel, Gravener, Joiner, & Haedt, 2010), one third cycle through recovery and relapse (Grilo et al., 2007), and 16% go on to develop an eating disorder (Fairburn & Harrison, 2003; Herzog, Hopkins, & Burns, 1993).

Enhanced understanding regarding how IPV experiences relate to altered eating behaviors is needed to more appropriately tailor assessments and interventions. Although the aforementioned studies show a consistent association between IPV and eating behaviors, the quantitative survey designs used do not allow a deeper understanding on how the experiences of IPV and disordered eating overlap and thus are unable to elucidate the mechanisms through which altered eating behaviors can arise from IPV. To address this knowledge gap, we conducted a qualitative study interviewing female victims of IPV about their eating behaviors and how they perceive their experience of IPV affects these behaviors. Herein, we present a broad spectrum of victims' self-described, altered eating behaviors and their perceived etiology of these behaviors

Method

Research Design

We choose a qualitative design to allow the women to share their thoughts, beliefs, and experiences in their own words without imposing on them any preconceived ideas or theories. Qualitative approaches explore topics from the perspectives of the participants themselves and allow for richer, more in-depth understanding of the various social, emotional, and cultural contexts associated with their experiences (Giacomini & Cook, 2000a, 2000b; Patton, 2002). Based on the lead author's experience of leading health education discussions with female IPV victims, focus groups were chosen as the main method of data collection. Early in the course of the research, however, some potential volunteers voiced concern about sharing their thoughts and experiences in a group setting. After considering these concerns and consulting with advocates, the research team decided to add the option of individual interviews. As a result, participants were offered the option to participate either in focus groups or individual interviews.

Study Participants

Women using support services and/or shelter services at a local domestic violence shelter in Pittsburgh, Pennsylvania, were recruited for this study.

Table 1. Focus Group or Interview Guide.

What role does food and diet play in your life?
How can intimate partner violence (IPV) affect your eating habits?
How did your eating habits during the abuse compare with your eating habits during periods without abuse?
What role did food and diet play in your experience with IPV?

Focus groups were formed from existing shelter support groups. Shelter staff assisted in identifying three support groups whose members had good rapport conducive for comfortable discussion of IPV and eating issues. For individual interviews, we used fliers posted in the shelter for recruitment.

Victims were assured that participation in the study was completely voluntary and anonymous and that refusal to participate would not affect the services they received at the shelter. Participants chose to give either their verbal or signed consent to participate at the time of enrollment. Women received a US$20 gift certificate to a local supermarket and brochures on nutrition for their participation in the study. The study was approved by the Institutional Review Board at the University of Pittsburgh and by the shelter's director.

Data Collection

All focus groups and individual interviews took place in a private conference room at the shelter. A designated shelter advocate was available outside the conference room for immediate support if any participant might have become distressed during the focus group or interview. At the start of each session, each participant completed an anonymous survey collecting demographic information, including age, race, marital status, income, education, and self-reported height and weight. Body mass index (BMI) was calculated based on this self-reported height and weight. Participants were also asked about their health information seeking behaviors, self-reported previous diagnoses of eating disorders, various types of IPV experiences, and any experiences of childhood abuse.

All focus groups and individual interviews were conducted by the first author. The same interview guide was used for both the focus groups and individual interviews (Table 1). Focus groups and individual interviews lasted approximately 1.5 hr and were audio-recorded.

We continued to recruit participants for individual interviews until thematic saturation was attained (Glaser & Strauss, 1967); that is, when information shared by participants became redundant and no new themes were raised with subsequent interviews.

Data Analysis

Audio-recordings were transcribed verbatim and purged of any personal identifying information. All transcripts were reviewed for accuracy and correlation with interviewer's recollection of the discussion. To safeguard against confirmation bias and establish triangulation between investigators (Patton, 1998, 2002), each author independently coded each transcript. The coding scheme was created in an emergent or iterative manner—we did not begin with an established coding scheme in mind but instead assigned interpretive codes to the text as we reviewed each transcript. Authors met after coding each transcript to review and compare codes, and discrepancies in codes were arbitrated until consensus was reached. A final coding scheme was developed and then re-applied to all transcripts. Both investigators examined the relationships between codes and identified thematic patterns and trends. Final corroborating steps included (a) presenting the themes with advocates from the shelter and (b) presenting the themes at a national IPV research meeting. Feedback at both presentations indicated that our findings resonated with the experiences, perceptions, and expertise of these IPV victims' advocates and researchers. Atlas*ti (version 5.0; Atlas.ti Scientific Software Development Gmbh, Berlin) qualitative data analysis software was used to assist in recording and organizing codes.

Results

Twenty-five women participated in our study (Table 2): 19 women participated in the three focus groups and 6 women were individually interviewed. Nine women were residing at the shelter whereas 16 women were non-residents. Participants' mean age was 42.2 years (±12.5 years) and their mean BMI was 28.9 kg/m^2 (±6.5 kg/m^2). Most women were Caucasian, were unemployed, possessed household incomes less than US$10,000 per year, and had some college education (72%). Four women (16%) were married or cohabitating with their abusive partners (16%). Physical (80%) and verbal/psychological forms of abuse (84%) were the most common forms of abuse experienced by victims in their intimate relationships. A history of childhood abuse was present in 19 (76%) women. Two women (8%) reported having been previously diagnosed with an eating disorder (bulimia nervosa) and 11 women (44%) had previously sought information on diet or weight from their health care provider.

Relationship Between IPV and Eating Behaviors

Analysis of transcripts identified several dominant themes describing the influence of IPV on the evolution of victims' altered eating behaviors: (a)

Table 2. Characteristics of Participants (*N* = 25).

Characteristic	Percent
Type of participant	
Focus group	76
Individual interview	24
Shelter status	
Resident	36
Non-resident	64
Marital status[a]	
Single	32
Married or cohabitating	16
Separated, divorced, or widowed	44
Race/ethnicity	
African American/Black	40
Caucasian/White	60
Unemployed	52
Household income[a]	
US$10,000 or less	44
US$10,001-US$29,999	36
US$30,000 or greater	16
Education	
High school or less	28
College or higher	72
Form of IPV experienced	
Physical	80
Sexual	36
Verbal/psychological	84
Form of child abuse experienced	
Physical	40
Sexual	28
Verbal/psychological	64
Sought information on diet or weight	
From health care provider	44
From IPV advocate	16
Previous diagnosis of	
Anorexia nervosa	0
Bulimia nervosa	8

Note. IPV = intimate partner violence.
[a]Does not sum to 100% due to no responses.

avoiding abuse, (b) somatization, (c) coping, (d) self-harm, and (e) challenging abusive partners.

Avoiding Abuse

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. One woman reported having been violently force-fed.

When women tried to eat healthily, their attempts were ridiculed by their partners. One woman described this challenge, "To be made fun of for the way you want to eat, the things you like and that are good for you . . . That's a big struggle to be respected for your needs." The women described having to adapt their eating behaviors or food choices to avoid abuse by their partner. For another woman with an underlying medical illness, this led to serious complications and hospitalization:

> I got sick and in the hospital because I didn't have my diabetes under control . . . In my situation, it was more of [my partner] controlling me, what I could eat, when I could eat, if I could eat . . . And I know it wasn't in my best interest health-wise, but I would . . . eat what [my partner] would want me to eat just to keep the peace because that was the easier thing to do than to pay the consequences.

Somatization

Victims described significant gastrointestinal symptoms, such as abdominal pain, loss of appetite, and nausea, associated with their IPV experiences. The severity of these symptoms prevented women from eating. As one woman explained, "Because I have so much of that frustration and so much of that being terrified, my stomach would turn up into such big knots. There was nothing that would have sat in my stomach." A few women reported that these symptoms occurred frequently and for prolonged periods, leading to significant weight loss. In contradistinction, when women felt safe from their abusers, they noted a return in their ability to eat. As one woman described, "The night I got [to shelter] and I was feeling alright and safe, I just started eating everything."

Coping

All women described chronic psychological distress, such as depression, anxiety, and hopelessness, as a result of IPV. Eating food was generally regarded

as a pleasurable act; the women noted that they regularly consumed food to cheer themselves up and manage their depression. One woman stated, "When I was down or he made me mad, I would eat a banana split and it would be a big one and it would always make me feel better." Women expressed feeling numb from the abuse and used food as a stimulant or to lift their spirits. Said one woman, "Ice cream would give me a jolt . . .I was really depressed, and I wanted a lift, I wanted a pick-me-up, so I would get chocolate ice cream." Food also served the purpose of filling an emotional emptiness. Another woman explained, "When I'm upset and emotional, it feels very empty . . . I [eat] because somewhere it does feel good and somewhere it does fill a void."

In the absence of their partners' and other social support, a few women regarded food as a source of comfort. Several women described food as a "friend" that filled a perceived void. As one woman explained,

> I feel very isolated in this relationship and I feel very alone in the relationship . . . There's a comfort in just knowing that there's someone there that I sort of belong to and that belongs to me . . . Just always having food to fall back on and sort of be my friend.

Another woman expressed, "Food has always been one of the things I found love in almost unconditionally." In turning to food to treat their psychological symptoms, other women likened food to a kind of medicine: "We assumed eating because it deals with the pain in our lives . . . When we feel the pain we have from our wounds, we use food to nurture it, to self-love."

Self-Harm

Although the women described use of food as a method of coping, the women also acknowledged that often this would instead lead to some harm. Many of the women who repeatedly returned to food to cope discussed difficulties with over-eating and weight gain. As one woman shared, "I would eat. Sit down, make a cake and eat the whole cake. I go buy a chicken and eat the whole chicken. That's how depressed I was." Excessive eating often gave way to feelings of guilt and anger: "The comfort doesn't shut off until there is nothing else to eat, and then I sit there and I say, 'what an idiot you've been.'"

For some women, food and eating were also used as forms of self-abuse. These women described this self-punishment as eating until they feel sick or behaving in a manner they find repulsive to mirror how they feel about themselves. One woman addressed the duality of food in her life in this manner, "[Food] is both comfort and punishment. Comfort when I'm feeling innocent

from abuse. And punishment when I'm convinced that the abuse was valid." Another woman explained,

> . . . That is kind of what I was talking about, about eating even beyond the feeling of when food comforts me, eating beyond that. And I know, I know even as I'm doing it, it's a passive aggressive stab in some way at him and myself . . . One of the things that he has historically said . . . or . . . implied . . . is that I'm lazy. And so, to me, when I think of lazy, I think of someone that's sitting on the couch stuffing their face. And so, I, I know that that's one of the things that I'm doing is, "you want to see lazy? I'll show you lazy." (laughs, others laugh). This is me, it's 10 o'clock at night, I'm watching TV, sitting on the couch, stuffing my face until I'm sick.

Abusers' insults, particularly about victims' body and appearance, injured victims' self-esteem and self-image. Many women described how they internalized their partners' persistent criticisms and knowingly ate unhealthily because they believed there was no purpose in striving for a desirable weight and diet. In this manner, these women had used food to make themselves as unattractive as their abusers made them feel. The women agreed that when food was consumed in a way that harmed themselves, such behaviors were "self-sabotage." As one woman stated, "You are using [food] to abuse yourself. You're joining, locking arms with your abuser, abusing yourself even in his absence."

Challenging Abusive Partners

Several women saw eating and their weight as an aspect in their lives that their partners did not have complete control over. A few women would starve themselves to demonstrate the strength of their self-control and willpower, which gave them a sense of confidence. As one woman explained, "Our abusers were all really controlling and they controlled so much of our lives that the one thing that they can't control is what you put in your mouth." Another woman also shared how she used food and eating to exert some control:

> During the abuse, I didn't eat because he was determined to make me feel bad about myself and I didn't want to give him the satisfaction, so I would starve myself, so I don't gain weight. But I was losing and losing, it was unhealthy, but that was my way of keeping my confidence and keeping him from breaking me.

Discussion

Our study findings suggest a variety of pathways in which altered eating behaviors may be linked with IPV among victims. Whereas some of these pathways

are direct, such as abusive partners controlling what and how victims eat, most are indirect wherein victims' altered eating behaviors reflected responses to how IPV affected their sense of control, happiness, self-esteem, and power in their intimate relationships. These pathways described were often overlapping with women often describing experiencing more than one simultaneously such as the use of food to both self-soothe as well as self-punish.

Our study participants' descriptions of how their partners controlled their eating and disrupted their attempts at maintaining healthy diets corroborates work by Martin and Younger-Lewis who compiled a list of abusive behaviors from men's descriptions of how they controlled or harmed their wives or girlfriends. This article mentioned eating and food-related abusive behaviors including "throwing food," "forced cannibalism," "force-feeding her," and "denying or restricting her food and drink" (Martin & Younger-Lewis, 1997). Our findings add to this list with descriptions of how abusive partners may control victims' food choices and interfere with attempts to eat more healthily. Prior studies have described other manifestations of perpetrators' interference with victims' health promoting behaviors including preventing victims from seeing their doctor (McCloskey et al., 2007), sabotaging victims' use of birth control methods (Miller et al., 2010), and withholding care or medicines among women with physical disabilities (Nosek, Foley, Hughes, & Howland, 2001). Understanding how IPV perpetrators may control victims' eating is particularly relevant for IPV victims with medical conditions such as diabetes, celiac disease, or hyperlipidemia where adherence to particular food choices and eating patterns are necessary to avoid complications or exacerbations of their disease. For example, when addressing poor disease management or non-compliance with prescribed dietary regimens among IPV victims, health providers should consider the possibility of perpetrator interference. Interventions in these situations would then focus more on strategies for safety-promotion and less on nutritional education.

Our findings regarding indirect pathways linking IPV and altered eating behaviors suggest that food and eating had diverse psychic functions for victims. The somatization, coping, and self-harm themes describe some psychological reactions to their IPV experiences that reflect findings and theories exploring the associations between altered eating behaviors and other victimization experiences (Bonomi et al., 2009; Farber, 2008; Masheb & Grilo, 2006). Our participants' descriptions of how gastrointestinal symptoms such as pain and loss of appetite affect their eating behaviors support prior studies that found associations between histories of IPV and gastrointestinal disorders such as irritable bowel syndrome and chronic abdominal pain (Bonomi, 2009; Drossman, 1995; Keeshin, Cronholm, & Strawn, 2012; Kernic, 2000; Perona, 2005).

The tendency to use food to cope or regulate affect, alleviate psychic pain, and dissociate from painful states or situations caused by IPV correlates with prior studies examining emotional eating or eating in response to experiencing negative affect such as anger and frustration (Arnow, Kenardy, & Agras, 1995; Geliebter & Aversa, 2003; Masheb & Grilo, 2006). In addition, our participants' description of using eating or food to self-punish has also been described as a phenomenon associated with altered eating behaviors. For example, Farber's work examining the relationship between traumatic attachments, self-mutilation behavior, and disordered eating behaviors described women for whom their bodies became a place to act out feelings of guilt, and shame about their abusive relationship (Farber, 2008). Although Farber's observations focused more on traumatic attachments from childhood, such as parental maltreatment or neglect, her theories on how these relationship experiences may be internalized by victims and result in self-harming behaviors appear applicable to our population of IPV victims (Farber, 2008).

A unique finding in our study is the use of food and eating as a method of challenging or opposing their abusive partners. Although not previously described among studies of IPV victims, the concept of using food and eating as a method for asserting control has certainly been used as a political strategy among protestors and prisoners who wage "hunger strikes" to express rebellion or leverage for demands. Some theories regarding the psychocognitive etiology of anorexia nervosa argue that this disorder may be related to a fixation on the body and a desire to triumph over food due to a person's misplaced desire for control in the other aspects of her life (Fairburn, Shafran, & Cooper, 1999). Additional research will be needed to better understand this process of using eating behaviors to resist or rebel against one's abusive partner.

While these qualitative findings provide some insights that, in turn, can lead to the development of hypothesis that can be explored in future studies, there are some limitations that warrant mention. First, as is the case for most qualitative work, generalizability is limited. Although we noted saturation by the fourth interview, we recognize that a larger, broader sample could have elicited more varied findings. For example, our sample was drawn entirely from women who were using IPV victims' services such as shelter and counseling. Thus, the results may not hold true for women experiencing IPV who had not sought support services. In addition, the majority of our study participants (76%) reported having experienced child abuse as well as IPV. Prior studies indicate that altered eating behaviors are twice as prevalent among victims of child abuse as compared with non-victims (Smolak & Murnen, 2002). With the large overlap of participants who experience both types of victimization, it may be difficult to fully distinguish how much their described

altered eating behaviors could be attributed to which type of victimization. However, our interview questions asked the women to describe how they felt their eating behaviors related specifically to their IPV and not to other victimization experiences. We also recognize the possibility of selection bias as women who may have perceived an association between IPV and eating issues may have been more likely to participate. Nonetheless, that there *are* some women who perceive this association to us is an important finding that broadens and deepens our understanding of the scope of IPV and its potential effects on women's lives and health. In addition, the majority of our sample was Caucasian and educated. While we did not note any differences related to either race or educational level in our coding or themes, there is a possibility that inclusion of more women from other races/cultures and with varying educational experience could have elicited a greater diversity of ideas and experiences regarding IPV and eating/food.

Although we asked participants to self-report any diagnoses of anorexia nervosa or bulimia on their demographic forms, we did not use any standard assessments used to establish or confirm these diagnoses. In addition, we did not specifically ask about other more common altered eating behaviors such as binge eating or eating disorders not otherwise specified. Our intent was to focus on women's descriptions and perceptions of their eating behaviors and how IPV may or may not have influenced these behaviors rather than to establish any definitive associations between IPV and eating disorder diagnoses. Future studies are needed to explore how and whether the constellation of eating behaviors described by our participants are associated with negative health consequences.

Despite these limitations, our study findings offer useful contributions to the field by illustrating how IPV can lead to altered eating behaviors. This has implications for health providers, particularly those who work with individuals struggling with disordered eating behaviors. Health providers should inquire about IPV when they identify patients who describe altered eating behaviors and consider how these conditions may overlap when devising intervention strategies. As an example, erratic glucose assessments in a previously controlled diabetic woman whom a provider knows is an IPV survivor may alert the provider to potential escalation in violence or threat. Interventions with these patients should then address safety and self-empowerment as well as nutrition and healthy eating. In addition, our study findings have practice implications for IPV victims' advocates. Advocates may wish to directly ask about eating behaviors to understand the impacts of clients' IPV experiences as well as tailor the resources, counseling, and support to include healthy eating as a method of reasserting self-control and self-worth in the healing process.

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Author Biographies

Susan P. Y. Wong, MD, is an acting instructor in the Department of Medicine at the University of Washington. She designed and conducted this research project while she was a medical student at the University of Pittsburgh. She has been recognized for community service activities benefitting at-risk individuals.

Judy C. Chang, MD, MPH, is an associate professor of obstetrics, gynecology, and reproductive sciences and internal medicine at the University of Pittsburgh. She is a women's health services researcher who has been performing research on IPV for over 15 years.