# Clinical Impact of Intimate Partner Violence and Childhood Trauma on Psychiatric Disorders

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**Abstract**

Gender-based violence – including physical, sexual, emotional and economic violence and abuse is widespread globally. The most pervasive form of gender-based violence is intimate partner violence (IPV), also known as domestic violence or partner/spouse abuse. On average, 30% of women worldwide will experience at least one episode of sexual and/or physical IPV within her lifetime; the incidence and prevalence of violence in relationships, however, varies greatly both between countries and regions, and between neighborhoods and villages. Decades of research have demonstrated that the health consequences of violence are cumulative and long term and extend far beyond injury. They include immediate and longer term physical and mental health outcomes such as chronic pelvic pain, HIV and other sexually transmitted infections (STIs), unwanted pregnancy, adverse pregnancy outcomes, suicidal ideation, depression and increased risk of homicide. Children and adolescents experience high rates of physical, sexual, and emotional maltreatment by caretakers. For instance, the 2013–2014 National Survey of Children's Exposure to Violence indicated that 15% of children and teens experienced at least one form of child maltreatment (physical, sexual, or emotional abuse, neglect, or custodial interference or family abduction) in the previous year. Childhood physical and sexual maltreatment have been associated with a range of negative consequences, including both IPV perpetration and victimization. Studies such as these suggest a causal relationship between prior victimization and later perpetration of violence via the intergenerational transmission of violence or "the cycle of violence," whereby children who experience family of origin violence are more likely to learn the utility of violence and model violence in their own relationships. According to this perspective, individuals who experience family of origin abuse may be more likely to accept violence as an expected aspect of interpersonal relationships and experience an increased risk of relationship violence

victimization as well. Conversely, they may be at risk for perpetrating subsequent IPV because they have seen it modeled in their family environment.
**Keywords:** Intimate partner violence, Childhood Trauma

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**Introduction:**

Gender-based violence – including physical, sexual, emotional and economic violence and abuse is widespread globally. The most pervasive form of gender-based violence is intimate partner violence (IPV), also known as domestic violence or partner/spouse abuse. On average, 30% of women worldwide will experience at least one episode of sexual and/or physical IPV within her lifetime; the incidence and prevalence of violence in relationships, however, varies greatly both between countries and regions, and between neighbourhoods and villages (1).

Decades of research have demonstrated that the health consequences of violence are cumulative and long term and extend far beyond injury. They include immediate and longer term physical and mental health outcomes such as chronic pelvic pain, HIV and other sexually transmitted infections (STIs), unwanted pregnancy, adverse pregnancy outcomes, suicidal ideation, depression and increased risk of homicide (2).

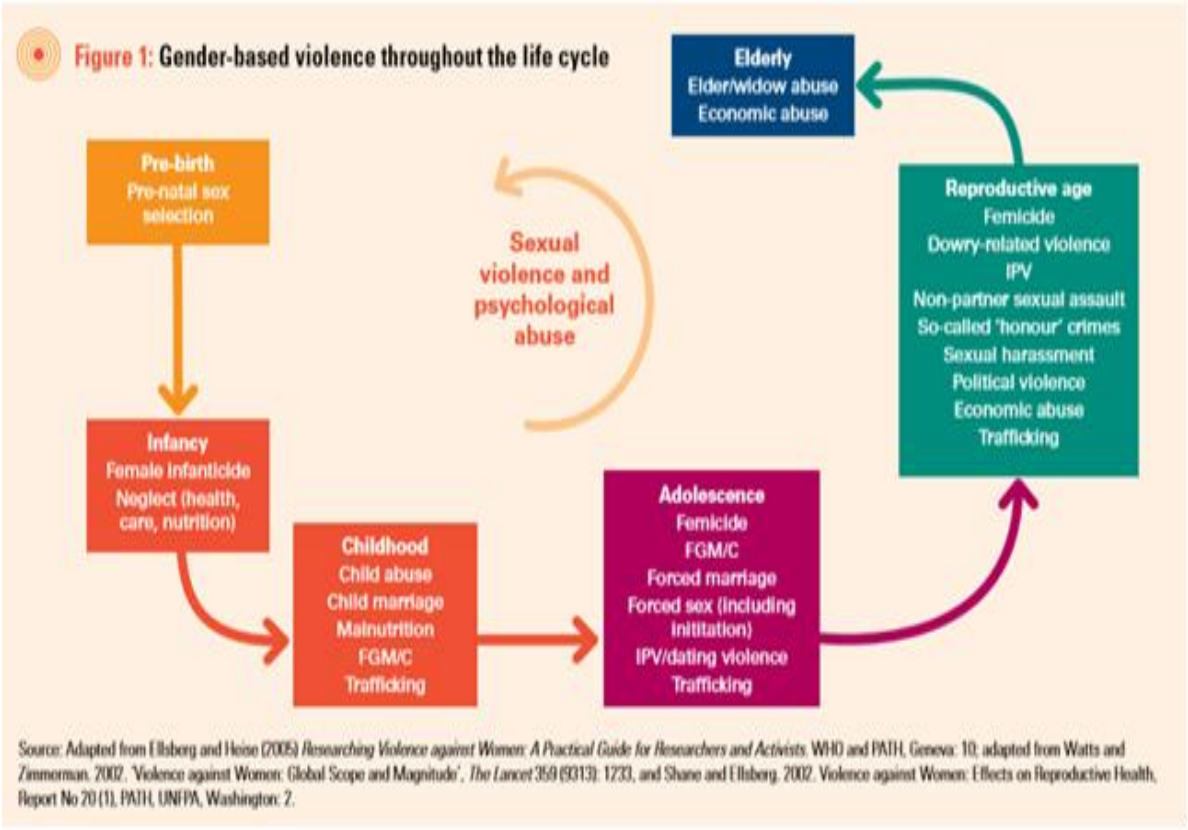
Partner violence also affects a range of other development outcomes, including infant and under-5 child mortality, women's political participation and women's ability to better their economic prospects through micro-finance and savings schemes. As a result, there has been increasing interest in exploring whether, and under what conditions, violence in relationships may be associated with other health, development and socio-economic outcomes. IPV can be defined as a pattern of behavior within an intimate relationship that includes physical or sexually violent acts, often accompanied by emotional aggression and controlling behaviors, enacted by a current or former intimate partner (i.e. spouse, boyfriend/girlfriend, dating partner, or ongoing sexual partner).

Partner violence includes:

- Physical aggression–such as slapping hitting, kicking beating
- forced intercourse or other forms of sexual coercion
- Psychological abuse–such as intimidation, constant belittling and humiliation
- controlling behaviors such as isolating person from their family and friends, monitoring their movements and restricting their access to assistance or information.

IPV is part of a larger category of abuses called violence against women (VAW) or gender-based violence (GBV). The acronyms VAW and GBV are often used interchangeably because most gender-based violence is perpetrated by men against women and girls. Violence against women

includes a range of abuses that extends throughout the life cycle, from sex selective abortion and child sexual abuse, to so-called 'honour' killings and female genital cutting. (2).




Source: Adapted from Ellsberg and Heise (2005) *Researching Violence against Women: A Practical Guide for Researchers and Activists*. WHO and PATH, Geneva: 10; adapted from Watts and Zimmerman. 2002. 'Violence against Women: Global Scope and Magnitude', *The Lancet* 359 (9313): 1233, and Shane and Ellsberg. 2002. Violence against Women: Effects on Reproductive Health, Report No 20 (1), PATH, UNFPA, Washington: 2.

Adverse childhood experiences (ACEs) designate the most common sources of stress that children may suffer early in life, including ten categories; abuse (physical, emotional & sexual), neglect (physical & emotional) and household dysfunction (household member treated violently , incarcerated household member ,parental separation or divorce, mental illness & substance abuse in household (3) .

Epidemiological data show that adolescence is the developmental period of highest risk of exposure to many types of potentially traumatic events (PTEs), including interpersonal violence, accidents, injuries, and numerous traumatic network events (4).

Using data from the National Co morbidity Survey Replication Adolescent Supplement (NCS-A), a population-based sample of U.S. adolescents, to describe the epidemiology of PTE exposure found that most adolescents (61.8%) reported at least 1 lifetime PTE (29.1% reported 1 PTE, 14.1% 2 PTEs, and 18.6% 3 or more PTEs). Exposure to PTEs, particularly interpersonal violence, was highest among adolescents not living with both biological parents and with pre-existing behavior disorders). Traumatic events experienced during development may damage neurobiological

and neuroendocrine aspects, which remain for the rest of one's life. The effects of early life stress (ELS) affect child development in behavioral, emotional, social, physical, and cognitive areas **(5).**

The experience of childhood maltreatment, defined as emotional, physical and sexual abuse, or emotional and physical neglect, increases the risk of developing physical illness or mental disorders in adulthood and is associated with substantial costs to the individual and society **(6).**

Previous research investigating the role of childhood maltreatment in the development of psychopathology has mostly focused on mental disorders such as posttraumatic stress disorder (PTSD), affective disorders, personality disorders, and substance use disorder **(7).** There is also preliminary evidence that child abuse and neglect plays a role in the development and maintenance of obsessive-compulsive disorder (OCD), but this evidence is limited and inconsistent.

**Impact of childhood maltreatment on obsessive compulsive disorder:**

A positive relationship has been detected between the presence of many psychiatric disorders such as dissociative disorders, anxiety disorder, post-traumatic stress disorder, borderline personality disorder, somatization disorder, antisocial personality disorder, alcohol and substance dependence, depression, conversion disorder, inattentive personality disorder, psychotic disorders and trauma story in childhood. In addition to these disorders, it was shown in some studies that obsessive-compulsive disorder (OCD) which is characterized by ego dystonic, disturbing, repetitive, anxiety-provoking thoughts (obsessions) that disrupt the social and occupational functioning of the person and repetitive behaviors or mental actions that are performed to reduce the anxiety (compulsions) may be associated with trauma in childhood **(8).**

Although increased prevalence rates of childhood maltreatment among patients with OCD compared to controls have been found in the majority of previous studies **(8).** other studies – all with large sample sizes and thus adequately powered – did not find heightened prevalence rates for any kind of childhood trauma in OCD patients **(9).**

Moreover, especially findings regarding the subtypes of childhood maltreatment are inconsistent across studies. For example, increased rates of sexual abuse among patients with OCD have been found in some studies, but not others **(8).** Elevated levels of emotional abuse and/or emotional neglect among patients with OCD have been found more consistently **(11).** However, not all studies have differentiated between various subtypes.

Few studies have examined whether the experience of maltreatment is related to the severity of OCD symptoms. Results from studies in subclinical samples have mostly supported such a link. Higher levels of childhood maltreatment were associated with increased OCD symptom severity in two large college student samples **(10)** as well as in a general population sample. However, in the latter study this link was fully mediated by current levels of anxiety and depression. With respect to clinical samples of patients with OCD, the results have been less clear.

In a study including 120 patients with OCD, childhood trauma was associated with higher OCD symptom severity. This was particularly the case for sexual, physical and emotional abuse, and emotional neglect. However, these findings did not control for multiple testing or potentially confounding factors such as anxiety or depression. Conversely, a number of studies involving patients with OCD have not found a relationship between levels of childhood maltreatment and OCD severity **(11).**

Clarifying the role of childhood traumatic experiences in OCD is important, in part because the presence or absence of a link between childhood trauma and severity of OCD may have clinical implications.

OCD is one of the most chronic forms of psychopathology **(12),** and one relevant clinical question is whether early traumatic experiences should be addressed in patients with OCD who do not respond to gold standard treatments such as exposure and response prevention.

There is only limited data on the impact of traumatic experiences on OCD treatment. Indirect evidence comes from two studies suggesting that a diagnosis of co-occurring PTSD in individuals seeking treatment for OCD leads to poorer treatment outcome (no change or a worsening of symptoms) than for individuals without a trauma history. Moreover, in another study reduction in OCD symptoms during treatment were associated with an increase in PTSD symptoms (i.e. intrusions), which may suggest that OCD symptoms may be a coping strategy against PTSD symptoms **(13).** Importantly, however, both studies did not differentiate childhood abuse and neglect from other types of trauma of trauma and did not investigate the impact of trauma on OCD treatment in the absence of PTSD symptoms.

Only two studies to date have directly investigated the association between childhood trauma and OCD treatment outcome. In the first study, increased rates of childhood maltreatment were found among treatment-resistant OCD patients compared to treatment responders, in particular for sexual, physical and emotional abuse, and emotional neglect **(14).** Second in a small sample of patients with OCD (N = 41),

Patients with a history of childhood abuse and neglect showed higher symptom severity at the beginning and end of treatment than those without these traumatic experiences, although at the end of the treatment both groups were similarly improved. It is known that living traumatic events during childhood, when the individual is vulnerable and needs to be protected, may be associated with neurobiological changes and is associated with an increased risk of developing psychiatric disorders in adulthood **(15).**

Also, psychological traumas in childhood may not only cause the emergence of obsessive compulsive symptoms but also may influence them so that they progress, increase in intensity and/or frequency, and change in terms of content. In the study by **Murphy et al. (16)** in a nonclinical sample, they reported that more obsessive-compulsive symptoms were reported in adult women who

were exposed to **sexual assault** during their childhood. In a study conducted on an on-clinical sample, it was reported that there were significant relationships between childhood traumatic experiences, more pronouncedly with **emotional traumas**, and obsessive-compulsive symptoms **(17).**

In another study performed on 120 patients who were diagnosed with OCD in our country, it was determined that there was a positive correlation between childhood trauma and obsessive-compulsive symptoms. In the same study, trauma scores in treatment-resistant OCD patients were reported to be higher than those of the other OCD patients.

Childhood trauma was also associated with personality disorders (especially with borderline personality disorder), schizophrenia, anxiety disorders (especially with posttraumatic stress disorder), substance abuse disorders, mood disorders (especially with major depression and bipolar illness), disruptive behavior disorders, and eating disorders **(18).**

**Child maltreatment as risk for substance use disorder:**

Child maltreatment has been frequently identified in the life histories of adolescents and adults in treatment for substance use disorders (SUDs), as well as in epidemiological studies of risk factors for substance use and SUD. For instance, individuals who experienced maltreatment during childhood are at risk for an earlier initiation into drinking, faster increases in heavy episodic drinking during adolescence **(19).**, and persistently elevated heavy episodic drinking throughout adolescence and young adulthood **(19).**

Indeed, childhood emotional maltreatment, physical maltreatment, and sexual abuse have each been associated with increased risk for tobacco use, alcohol use, illicit drug use, and poly drug use. Furthermore, adolescent girls with a history of childhood sexual abuse are approximately five times more likely to be heavy poly substance users compared to adolescent girls without experiences of childhood sexual abuse **(19).**

Although numerous forms of childhood adversity have been linked with risk for substance use later in development, **Elliott et al. (20)** found that over and above other forms of childhood adversities (e.g., parental death, parental incarceration, parental divorce), child maltreatment uniquely predicted persistent alcohol dependence in adulthood.

**Child maltreatment as risk for suicide:**

There are also studies examining the relationship between childhood trauma and suicide. In a study on (55,299) people in 21countries, it was determined that child abuse increased the risks of suicide thought and suicide attempt, and that sexual and physical abuse had the strongest effect on suicidal behavior. Significant correlations were found between childhood traumas and suicidal thoughts and behaviors in the diseases such as depressive disorder **(21)** schizophrenia substance

abuse, bulimia nervosa. When the relevant literature was examined, in the studies which assessed suicide relationship with childhood traumas on the patients with depressive disorder. bipolar disorder (22), schizophrenia, posttraumatic stress disorder it was found that childhood traumas increase the risk of suicide. In resarch by Rukiye and Lale, a moderate correlation was found between CTQ total score and emotional abuse while mild correlation was found between suicide probability and physical neglect, physical abuse, independent of and BAS and BDS scores. Increased risk of suicide in the presence of childhood trauma in OCD patients may be related to serotonin functions of the brain.

The strain theory of suicide posited that suicide is usually preceded by some psychological strains (23). A strain is not simply a pressure or stress. People may frequently have the latter but not necessarily the former in daily life.

A pressure or stress in daily life is a single-variable phenomenon, but strain is made up of at least two pressures or two variables. Similar to the formation of cognitive dissonance but more serious and detrimental than cognitive dissonance, a strain pulls or pushes an individual in different directions, so as to make the individual frustrated, upset, angry, or even painful.

Examples include at least two differential cultural values, aspiration and reality, one's own status and that of others, and a crisis and coping ability. Like cognitive dissonance, strain is psychological frustration or even suffering for which one has to find a solution so as to reduce it or do away with it. But in truth, it is more serious, frustrating, threatening, and even painful than cognitive dissonance. The extreme solution for an unsolved strain is suicide. There are four sources of psychological strain that may cause suicidal ideation. Each of the four types of strain is derived from specific sources. A source of strain must consist of at least two conflicting social facts. If the two social facts are non-contradictory, there should be no strain.

The interpersonal theory of suicide **Joiner, 24** suggests that suicide is likely to happen to an individual who has experienced thwarted belonging, perceived burdensomeness, and acquired capability, and claims that this social disconnectedness plus the means and environment is the cause of suicide, the theory has been supported by numerous evidence-based studies, which all found a strong correlation between social disconnectedness/capability and suicide/suicidal ideation/suicidal behavior. The correlation is true and unarguable; however, it is not the root or ultimate cause of suicide.

***Intimate partner violence and Childhood Trauma; Overlap of perpetration and victimization***

Children and adolescents experience high rates of physical, sexual, and emotional maltreatment by caretakers. For instance, the 2013–2014 National Survey of Children's Exposure to Violence indicated that 15% of children and teens experienced at least one form of child maltreatment (physical, sexual, or emotional abuse, neglect, or custodial interference or family

abduction) in the previous year. Exposure to violence and victimization can be highly detrimental, both in the short- and long-term **(25).**

Childhood physical and sexual maltreatment have been associated with a range of negative consequences, including both IPV perpetration and victimization. Studies such as these suggest a causal relationship between prior victimization and later perpetration of violence via the intergenerational transmission of violence or "the cycle of violence," whereby children who experience family of origin violence are more likely to learn the utility of violence and model violence in their own relationships **(25).**

**Theories of cycle of violence:**

According to this perspective, individuals who experience family of origin abuse may be more likely to accept violence as an expected aspect of interpersonal relationships and experience an increased risk of relationship violence victimization as well. Conversely, they may be at risk for perpetrating subsequent IPV because they have seen it modeled in their family environment **(26).**

This rationale stems from social learning theory, which holds that individuals learn through observation and operant conditioning. In support, multiple studies have found empirical associations between family of origin violence and an increased risk of later IPV victimization and perpetration **(25).**

Consistent with these theoretical underpinnings (i.e., that abused children might become a perpetrator or victim of later IPV), studies examining childhood maltreatment and subsequent intimate partner violence have primarily examined victimization and perpetration of IPV separately; few have considered the impact of child maltreatment on subsequent victimization and perpetration of violence within intimate partnerships. It is possible that failure to consider this third category of victims and offenders masks important differences between those who are in a relationship with mutual violence versus those who are a victim (or perpetrator) only.

**Victimization VS Prepetration**

**Caetano, Ramisetty-Minkler, and Field (27)** examined the influence of childhood physical abuse on both IPV victimization and perpetration and found that among females, childhood physical abuse was associated with both perpetrating physical violence against their partner and experiencing physical victimization from their partner (i.e., bi-directional violence), while among males, childhood physical abuse predicted perpetrating physical partner violence only.

**Richards et al. (28)** examined the relationship between physical and sexual abuse and IPV "victimization only," "perpetration only," or "victimization and perpetration" (compared to no IPV involvement) among U.S. college students, findings showed that sexual abuse increased the likelihood of membership in the IPV victim-perpetrator group, but not membership in the victim-

only or perpetrator-only groups, while physical abuse was not associated with membership in any of the IPV groups (compared to no IPV involvement). Thus, it is possible that being both a victim and a perpetrator of IPV has a unique etiology with regard to the cycle of violence; that is, these studies suggest that various types of childhood victimization (e.g., physical abuse, sexual abuse) may influence subsequent victimization, perpetration, and victimization-perpetration differently for males and females.

***Childhood Emotional Abuse***

One type of maltreatment that has received less attention in the cycle of violence research, and virtually no attention in the bi-directional IPV literature, is the impact of (childhood emotional maltreatment). Emotional abuse is often omitted from scholarly examinations of childhood and adolescent trauma **(4),** but is both highly prevalent and potentially damaging to later outcomes. In fact, **Finkelhor et al. (**4) found that it was reported at overall greater rates than other types of maltreatment for respondents' ages 6–17 years old.

The nascent evidence of child emotional maltreatment and the cycle of violence has been mixed, though, with some studies finding that emotional abuse contributes to IPV meaningfully – and uniquely – apart from physical and/or sexual child abuse. For instance, **Seedat, Stein, and Ford (29)** found that among a large sample of women, childhood emotional abuse as well as sexual abuse were significantly associated with later intimate partner violence victimization, but physical abuse was not.

**Further, Crawford and Wright (30)** found that childhood emotional abuse predicted perpetration of relationship aggression among college students, when using a combined measure of physical, emotional, and sexual aggression, as well as separate measures, and when controlling for relevant predictors, such as other forms of child abuse. They also found evidence that childhood emotional abuse was related to intimate partner victimization.

**Hypothesis of childhood emotional abuse:**

The importance of emotional abuse to subsequent IPV involvement may be explained by attachment theory primarily because secure child-caregiver attachment is critical for children to develop working models of interpersonal relationships **(31).**

Secure child-caregiver attachment engenders in the child a strong sense of security and trust in the world as they mature, giving them the confidence to explore their environment and develop secure relationships with others over the life course. Conversely, insensitivity or unresponsiveness on the part of a primary caregiver(s) results in an insecure attachment in the child, causing feelings of fear and/or anxiety and a view that the world is characterized by rejection and an absence of safety.

Thus, child maltreatment, including emotional abuse, can contribute to insecure attachments that are associated with violence in later relationships **(31).** Indeed, theoretical conceptualizations

support the notion that emotional abuse may have differential impacts on an individual's ability to create and sustain healthy relationships. Childhood emotional abuse may prevent individuals from "learning" and "practicing" a range of important emotions in their formative relationships (e.g., relationships with caregivers), and as a result; victims may suffer emotional deficits that negatively impact their interpersonal relationships over the lifetime.

A limited emotional repertoire may consist of unhealthy strategies that facilitate risk for partner victimization (i.e., avoidance, freezing/stilling) and/or increase the likelihood for perpetration of partner abuse (i.e., protest, anger)

**Richards et al, (28)** examined the independent relationship of childhood maltreatment type (emotional, sexual, and physical) on IPV victimization and perpetration; then mutually exclusive categories of IPV involvement (victimization, perpetration, and victimization/perpetration) were investigated. Results uncovered significant relationships between child physical abuse and IPV victimization as well as IPV perpetration for males and females, but this effect was reduced when emotional maltreatment was added to the model.

When IPV victimization/perpetration was considered, maltreatment effects changed. For males, physical maltreatment remained significantly related to victimization only and physical, sexual, and emotional maltreatment were related to victimization/perpetration. **(28)**

For females, physical maltreatment remained significantly related to IPV victimization only and emotional maltreatment was related to perpetration only and to victimization/perpetration. Screening and intervention for maltreatment, including emotional maltreatment, among children as well as adults with IPV histories may be important to preventing first IPV experiences and stemming current involvement. **(28)**

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