Pain that Persists: The Lifespan Effects of Childhood Abuse and Intimate Partner Violence and the Struggle to Prevent and Address them

Kartika K. Palani

Abstract

This paper reviews empirical studies and literature reviews to analyze current knowledge of the relationships between childhood abuse, intimate partner violence (IPV), and physical and mental health as an adult. The general trend that a greater exposure to abuse leads to more severe adulthood mental and physical health degradation is established across many studies to date. Survivors of IPV and childhood abuse are much more likely to experience physical disease, mental disorders, and substance abuse in adulthood. Furthermore, victims of childhood abuse are likely to become victims or perpetrators of IPV in adulthood. Additionally, the paper thoroughly discusses prevention for childhood abuse (school-based and home-based programs), treatment for childhood abuse (victim-based and perpetrator-based), and treatment for IPV outcomes. Research on abuse is weakened by non-diverse samples, limited longitudinal work, and simply the hidden and stigmatized nature of abuse. Recommended directions for future empirical study are suggested, such as broader demographic representation, clearer and stronger methodologies, analyzing pathways and longitudinal studies.

Introduction

Abuse, either experienced in childhood or adulthood, is associated with profound physical and psychological impacts that shape health and functioning across the lifespan. Specifically, two particularly pervasive and impactful forms of abuse are childhood abuse and intimate partner violence (IPV). While they occur at different age ranges, both forms of trauma disrupt physical and mental well-being and increase vulnerability to chronic illnesses and personality disorders.

Childhood abuse, defined as physical abuse, psychological abuse, sexual abuse, or neglect inflicted upon infants, toddlers, adolescents, or teenagers, occurs at alarming rates. The scope of this issue is staggering; specifically, in 2009, 700,000 children were determined to be victims of childhood abuse just in the United States (Widom et al., 2012), and an estimated four children die each day as a result of abuse (U.S. Department of Health and Human Services). In adulthood, IPV constitutes physical, psychological, or sexual abuse on an intimate partner in a relationship. According to Pill et al. (2017), one in 17 women and one in 20 men reported experiencing violent behaviors from an intimate partner and these rates have continued to rise in recent years (Joseph et al., 2015). Therefore, it's clear that both childhood abuse and IPV not only share similar meanings but are also extremely prevalent and impactful.

Both childhood abuse and IPV result in long-lasting mental and physical outcomes that heavily impact the quality of life of victims, but these outcomes may differ based on the type of abuse. In terms of childhood abuse, victims are significantly more likely to struggle with numerous significant psychological

disorders, including depression, anxiety, complex post-traumatic stress disorder (PTSD), sleep difficulty, substance use, and personality disorders (Domond et al., 2023; Selph et al., 2013; Pill et al., 2017). In addition to the psychological suffering, the physiological outcomes of childhood abuse are severe and long-lasting. Adults with a history of childhood abuse are more likely to experience heart disease, diabetes, obesity, and inflammation (Widom et al., 2012). The psychological and physical impacts of childhood abuse are thus well-proven and not to be underestimated in their impact.

This established connection between childhood abuse and significant physical and mental impacts raises an important question as to how exactly these outcomes manifest over decades of varied life experiences. There is evidence to support that mental health problems that arise following childhood abuse may mediate long-term physical problems. Another possible pathway through which abuse results in long-term impact may be due to repeated stress leading to biological processes that damage the brain, i.e., allostatic load. Finally, experiencing trauma increases individuals' likelihood of engaging in destructive coping strategies throughout their life (such as substance misuse and disordered eating) which can, in turn, increase the vulnerability to develop psychiatric disorders and physical outcomes as cited by Springer et al., (2003). Therefore, in current research there are many possible pathways that likely work in conjunction with one another to explain the trend of negative psychological and physical health resulting from childhood abuse.

Similar to childhood abuse, the impacts of IPV on mental health and psychological functioning are often complex and chronic, not simply concurrent with the time of abuse. Psychologically, victims of IPV, just like victims of child abuse, are extremely likely to experience depression, PTSD, substance use, suicidal ideation, sleep disturbance, and complex PTSD (Lagdon et al., 2015; Pill et al., 2017). Physically, victims of IPV are likely to experience back pain, headaches, swollen/painful joints, and are more likely to experience cardiovascular problems (Dillon et al., 2013). As with childhood abuse, many of these outcomes appear to arise through intermediary health pathways such as sleep disturbance (Lowe et al., 2007).

Notably, both forms of trauma are significantly interconnected in compelling ways; the victims of childhood abuse are more likely to become either victims or perpetrators of IPV in adulthood, demonstrating bidirectionality that may be explained in part by gender. This statistically supported occurrence of revictimization implies a multi-generational cycle of abuse and is extremely important to research and fully understand.

This literature review will first discuss the long-term physical and mental impacts of both childhood abuse and IPV separately. It will then compare these impacts while discussing the connection between early childhood abuse exposure and later IPV experience. Finally, it will discuss prevention strategies for IPV and childhood abuse in addition to treatment for IPV trauma.

Consequences of Abuse

Physical and Mental Impacts of Childhood Abuse

Childhood abuse has well-documented and lasting effects on both mental and physical health in adulthood. Specifically, childhood maltreatment can contribute to adulthood mental and physical health issues ranging from depression and substance abuse to stroke and diabetes. Developing a more comprehensive understanding of the adulthood consequences and the mechanisms through which they result is crucial, especially to inform more effective prevention and treatment strategies.

The Adverse Childhood Experiences (ACE) Study (Felitti et al., 1998) represents a pivotal and well-known study of childhood abuse outcomes with robust research methodologies. Felitti and colleagues surveyed 9,508 adult patients about the respondents' experience with various childhood adversities related to psychological abuse, physical abuse, sexual abuse, and household dysfunction. Responses to the questionnaire were then analyzed with other data from participants' medical records, including 10 adulthood mental outcomes, and the prevalence of multiple physical health indicators. The researchers found a striking dose-response relationship: individuals exposed to four or more categories of adverse childhood experiences, compared to those who had experienced none, were 4-12 times more likely to experience alcoholism, drug abuse, depression, and suicidality (i.e., to attempt suicide); 2-4 times more likely to smoke, rate themselves as having poor health, have 50+ sexual intercourse partners, and experience STDs; and 1.4-1.6 times more likely to suffer from physical inactivity and severe obesity. They were also at much higher risk for emphysema, chronic obstructive pulmonary disease (COPD), diabetes, hepatitis, and skeletal fractures. Importantly, individuals who experienced one ACE were 65-93% more likely to experience additional adversities, reinforcing the dose-response relationship and compounding nature of early trauma. This study was one of the first to demonstrate just how significant and compelling the relationship between childhood abuse and adulthood well-being.

Cross-sectional empirical studies such as the ACE study are valuable for identifying broad associations between childhood maltreatment and later health outcomes among large, representative samples. However, they cannot establish causality nor temporality. They also do not account for confounding variables that may explain the observed adult health outcomes, thus weakening their claims. Longitudinal studies are therefore essential to understanding the temporal and causal relationships between early adversity and later well-being.

Widom et al., (2012) conducted a prospective longitudinal study that strengthened the findings of the ACE study. The researchers followed 908 children with documented cases of abuse or neglect (recorded between 1967 and 1971) and matched this group with 667 nonabused children in terms of gender, race, date of birth, and socioeconomic status (SES). Both groups were interviewed twice - first, 22 years after abuse (1989–1995) and, again 10 years later (2000-2005). Through their use of official records and findings from medical examinations, the researchers were able to avoid relying on self-reported data. Indeed, utilizing more objective sources strengthened the study design and provided robust evidence that childhood maltreatment increases the risk of physical disease in adulthood. Specifically, abused individuals exhibited higher rates of physical health problems, including poor peak airflow, vision

problems, elevated hemoglobin (associated with COPD and emphysema), and low albumin (linked to poor liver and kidney function). Specific forms of maltreatment predicted distinct health outcomes: physical abuse increased vulnerability to malnutrition and diabetes, neglect was associated with oral health and respiratory issues, and sexual abuse predicted hepatitis C and oral health problems. The longitudinal design of this study significantly strengthened the reliability of its significant findings and insinuates causality between childhood physical abuse, sexual abuse, and neglect and physical health outcomes in adulthood.

A similar study examined both immediate and long-term effects of abuse among adolescents 12-15 (Kaplan et al., 1998). Ninety-nine bused children were matched with 99 non-abused peers by age, gender, and community income. Interviews assessed current psychiatric disorders in the children and found that abused children were significantly more likely to experience major and unipolar depressive disorder, dysthymia, disruptive disorders, substance use disorders, and ADHD. The consistency between these findings and those of Widom et al. (2012) and Felitti et al. (1998) reinforces a temporal relationship between childhood maltreatment and adult psychopathology.

Patterns of abuse also vary by demographic factors such as race, gender, and age. White women are more likely to report emotional neglect than African American men and women, whereas African American men are more likely to report physical neglect than their White counterparts. Additionally, women are four times more likely than men to experience sexual abuse while men were twice as likely to experience physical abuse. Female survivors also demonstrate a higher risk for elevated HbA1c levels, a biomarker associated with diabetes. Additionally, the age at which abuse occurs also matters: The older the child is at the time of abuse, the more likely they are to suffer from immediate mental and physical health impacts as well as lifetime mental and physical health impacts. Interestingly, in older adults (ages 55-81) there appears to be less significant of a connection between current well-being and childhood abuse experience. While these findings are intriguing, further research is needed to fully understand the complexities of how gender, race, culture, age, and socioeconomic status shape the long-term impacts of childhood abuse, as this understanding can guide more targeted prevention strategies.

It is indisputable that childhood maltreatment results in pervasive and enduring health problems. But why? What are the mechanisms by which childhood abuse develops into these major health problems years after abuse? A literature review establishes 4 main pathways through which childhood abuse creates adult health problems (Springer et al., 2003). The first is the behavioral pathway; survivors of childhood abuse often engage in harmful coping behaviors such as substance abuse, disordered eating, smoking, and suicide attempts. The second is the social pathway; adult survivors of childhood abuse are much more likely to struggle with maintaining intimate and social relationships. This presents itself in high re-victimization rates and homelessness rates of these survivors. The third is the cognitive pathway; victims of childhood abuse can develop personal distorted attitudes and beliefs that can subsequently impact their health by creating emotional distress. These beliefs may include increased perception of danger, a sense of helplessness and powerlessness, decreased ability to trust, and self-acknowledgement of poor health. The final pathway is the emotional pathway; victims are more likely to develop depression and post-traumatic stress disorder (PTSD).

Among these mechanisms, the concept of allostatic load provides a biological explanation for how chronic stress from abuse leads to physical illness. The sympathetic-adrenal-medullary (SAM) and hypothalamic-pituitary-adrenal (HPA) axes regulate stress responses. This is beneficial in the short term, but repeated or long-term exposure to stress can impact brain activity in the hippocampus, amygdala, and prefrontal cortex, increasing vulnerability to depression. A study examined 12 stress-related biomarkers and conducted mediation analyses linking childhood abuse, allostatic load, and depression (Scheur et al., 2018). The results of the study established allostatic load as a mediator because childhood physical abuse predicted higher adult allostatic load, which predicted depression. Depression, in turn, increases risks for sleep disturbances, heart disease, alcohol abuse, and suicidal behavior. Thus, childhood physical abuse ultimately creates a vicious self-reinforcing cycle of physical and mental health decline. However, the mediating effect of allostatic load was not observed for sexual abuse, suggesting that different forms of maltreatment may operate through distinct biological mechanisms. Additionally, the study only focused on the correlation between allostatic load and depression, though it is clear that there are numerous other mental disorders that victims of childhood abuse can experience as adults. Therefore, while valuable insight on possible pathways, they are not fully defined and understood. There is a need for further research on the diverse mechanisms by which different types of childhood maltreatment can manifest over a long period of time into various psychiatric disorders and physical health outcomes.

It is clear that childhood abuse (whether it be psychological abuse, neglect, physical abuse, or sexual abuse) substantially elevates the risk of both mental and physical disorders in adulthood. Mental consequences include depression, PTSD, sleep complications, substance abuse, and eating disorders, while physical outcomes may include chronic obstructive pulmonary disease (COPD), diabetes, obesity, and cardiovascular disease. The established dose-response relationship highlights the cumulative harm of multiple adverse experiences. Still, significant gaps remain in understanding how demographic factors and biological and psychological pathways contribute to these outcomes. Further research in this area is essential for developing effective prevention programing and improving treatments for adult survivors. The next subsection will explore whether similar mechanisms and health impacts emerge in the context of intimate partner violence.

Physical and Mental Impacts of Intimate Partner Violence (IPV)

The mental and physical health impacts of intimate partner violence have been extensively researched in a robust body of literature. Immediate injuries stemming from IPV may heal within a couple of weeks or months, but the impacts of IPV on overall physical health are often chronic, persisting long after the abuse has subsided. For example, women may suffer from gynecological problems and chronic body pain as a result of their exposure to IPV. Mental health outcomes are also significant, often including depression, posttraumatic stress disorder (PTSD), sleep complications, and complex PTSD. Given the known significant and lasting impacts of IPV, it is important to understand the multifaceted effects of IPV across diverse populations in order to compare the outcomes of IPV with those of childhood abuse and consider effective treatment strategies for IPV.

An empirical study examined the long-term and indirect physical consequences of IPV (Campbell et al., 2002). Campbell and colleagues compared 201 women who had experienced physical or sexual abuse with 240 women who had never been abused. Their findings revealed that survivors of IPV had about a 50-70% increase in central nervous system problems (e.g., headaches, back pain, fainting, seizures), chronic stress symptoms (e.g., high blood pressure, loss of appetite, digestive issues, bad flu/cold), and gynecological conditions (e.g., sexually transmitted disease, vaginal infection and bleeding, fibroids, pelvic pain, urinary tract infections). These results were reinforced by Dillon et al. (2013) who reviewed 75 papers published between 2006 and 2012. This literature review emphasized the chronic body pains experienced by many women including back pain, headaches, swollen/painful joints, and noted an elevated risk of cardiovascular related conditions like heart attack, stroke, and heart disease. Together, these studies underscore that IPV causes long-lasting and chronic physical health conditions.

Although the association between IPV and long-term physical health outcomes in current literature is strong, the mechanisms in which they result remain clear. One such mechanism may involve the role of mental health disorders, which can act as intermediaries between IPV exposure and physical health outcomes. A study analyzing the sleep experiences of 17 survivors of IPV found that women who reported sleep disturbance also reported physical symptoms such as raised blood pressure, body aches, migraines, chronic fatigue, and digestion issues (Lowe et al., 2007). The results of this study align with the issues found by Campbell et al. (2002) and Dillon et al. (2013). Sleep disturbance is also often connected to other psychiatric disorders, such as depression and PTSD. Therefore, sleep disturbance may function as one possible pathway through which IPV leads to both physical and mental health decline.

The mental impacts of IPV are nuanced and intricately connected to one another. A systematic review of 58 studies (2204-2014) across cross-sectional and longitudinal designs, identified consistent associations regarding IPV, depression, PTSD, substance use, suicidal ideation, and sleep disturbance (Lagdon et al., 2015). Their synthesis emphasized that comorbid disorders are the norm rather than the exception: substance use often emerges as a coping mechanism for trauma, co-occurring PTSD and depression heighten the risk of suicidality, and anxiety–depression comorbidity contributes to sleep disruption. This interdependence among psychiatric symptoms is important to understand when it comes to treatment of IPV.

Among these mental health outcomes, PTSD is a particularly expansive research area. A literature review discusses empirical findings related to trauma responses to IPV, focusing on PTSD, complex PTSD, and re-victimization (Pill et al., 2017). The results were overwhelming: 97% of physical IPV survivors meet the criteria for PTSD. According to the DSM framework, PTSD involves four symptom clusters: intrusion (e.g., intrusive memories, flashbacks), avoidance (e.g., avoiding internal feelings about the event and external reminders of the event), negative alterations in cognitions and mood (e.g., negative beliefs about self and the world, inability to remember aspects of the event); and alterations in arousal and reactivity (e.g., sleep difficulties, concentration difficulties, excessive alertness). However, while classic PTSD typically results from single-event traumas (“Type I” events), IPV often constitutes chronic, prolonged exposure (“Type II” events). As a result, many survivors experience complex PTSD. Complex PTSD includes the aforementioned PTSD symptoms in addition to dissociation (e.g., feeling detached from oneself and/or reality), emotional dysregulation (e.g., uncontrollable emotions), somatic distress

(e.g., physical symptoms manifested from stress), and identity disturbance (e.g., distorted sense of self). Many individuals who have been exposed to IPV continue to report PTSD months or even years after the abuse. Therefore, although most research focuses on PTSD as an outcome of IPV, it is important to consider and research complex PTSD in relation to IPV in order to fully acknowledge victims' symptoms and improve treatment.

Gender also influences the presentation of IPV-related outcomes, an area that Dillon et al. (2013) studied along with their previously mentioned findings on the physical outcomes of IPV. Female victims of IPV are more likely to display PTSD and depression, whereas males are more likely to display anxiety symptoms. Additionally, individuals who had been exposed to violence as children were more likely to report encountering IPV as adult, a phenomenon that Pill et al. (2017) described as re-victimization in their paper that was focused on PTSD. Re-victimization can refer to victims of childhood abuse being more likely to experience IPV as adults and/or survivors of IPV being more likely to become involved in another abusive relationship. Re-victimization likely occurs because the mental health impacts of any one form of abuse puts an individual at risk to be in a similar abusive situation later on in life. Specifically, depression and PTSD are among the most likely to put someone at risk for re-victimization.

Because IPV encompasses physical, psychological, and sexual forms of abuse, identifying which type most strongly predicts adverse outcomes is essential for developing tailored prevention and intervention strategies. However, findings are inconsistent across studies and there is no clear-cut answer. The previously mentioned systematic review from Lagdon et al. (2014) illustrates that psychological abuse exclusively is particularly impactful in leading to severe psychiatric outcomes. Supporting this, a cross-sectional study surveyed 661 Portugese college students about their experience with psychological abuse, physical abuse, sexual abuse, depression, anxiety, and PTSD (Começanha et al., 2017). The study found that psychological abuse had stronger associations with depression, anxiety, and PTSD than physical or sexual abuse. Contrastingly, a cross-sectional empirical study surveyed 146 Hispanic women for psychological abuse, physical abuse, sexual abuse, physical health, mental health, health risk behavior (smoking, alcohol, and drug use), and socioeconomic status (Chen et al., 2009). This study found that sexual abuse led to the greatest risk of displaying adverse mental health outcomes, with 83.3% of sexually abused individuals displaying depressive symptoms compared with 80% for physical abuse and 64.5% for psychological abuse. Still, another empirical study that analyzed PTSD symptoms of 95 Lebanese women who had been in an abusive relationship for at least 3 months, indicates that 97% of victims of exclusively physical IPV exhibited PTSD symptoms (Khadra et al., 2014). These mixed findings suggest that each form of abuse contributes uniquely to mental health deterioration and that cumulative exposure to multiple forms of IPV may produce the most severe outcomes.

It is clear with current research that experiencing intimate partner violence can result in numerous mental health outcomes, (such as depression, anxiety, PTSD, sleep disturbance, substance abuse, and suicide attempts) as well as various long-term physical health outcomes, (such as chronic body pains, heart symptoms, and gynecological problems). A dose-response relationship is also established between IPV exposure and mental health. Despite extensive research, gaps remain in understanding the pathways that link IPV to long-term physical health, the role of gender, and the specific contributions of different abuse types. Continued investigation into these pathways is crucial for developing effective prevention,

screening, and treatment interventions that address both the physical and psychological outcomes of intimate partner violence.

Comparing Childhood Abuse and Intimate Partner Violence

Understanding childhood abuse and intimate partner violence (IPV) separately allows for meaningful comparison of their impacts. Specifically, there are similarities and differences between the long-term mental and physical impacts of both childhood abuse and intimate partner violence. Additionally, there are connections between individuals who have experienced childhood abuse and the likelihood that they will become victims (revictimization) or perpetrators of intimate partner violence.

Physical outcomes of IPV and childhood abuse often differ in significant and compelling ways. Research indicates that survivors of childhood abuse are more likely to develop chronic, diagnosable medical conditions in adulthood, such as chronic obstructive pulmonary disease (COPD), emphysema, diabetes, cardiovascular disease, and kidney or lung problems. In contrast, IPV is more frequently associated with immediate or localized physical consequences, including chronic pain, headaches, hypertension, and gynecological problems. While all outcomes can be long-lasting, it is clear that research focused on childhood abuse measures broader diagnosable conditions and disease while research on IPV discusses more focused physical outcomes. This difference may stem from methodological factors: studies on childhood abuse tend to be longitudinal, following victims into adulthood to observe disease development, whereas IPV research typically measures outcomes closer to the time of abuse. As a result, IPV studies often capture more immediate physiological symptoms rather than fully developed medical conditions. It is possible that IPV, if experienced over time, also contributes to later chronic illnesses; however, insufficient longitudinal data may obscure these longer-term effects. Alternatively, perhaps the young and developmental age at which one experiences abuse is in fact the most important factor that allows larger and more impactful conditions to manifest, and that is why they are not found as outcomes of IPV.

In contrast to these differences in physical health, mental health outcomes following childhood abuse and IPV exhibit remarkable similarity. Both types of abuse can result in substance abuse, suicidality, sleep difficulty, depression, difficulty maintaining personal relationships, and PTSD. Complex PTSD, a response to prolonged and repeated trauma, applies to both types of abuse. Childhood abuse constitutes a “Type II” traumatic event, mirroring the chronic nature of IPV and leading to comparable emotional dysregulation, dissociation, and identity disturbance (Pill et al., 2017).

Also notable, a substantial body of empirical research meaningfully links childhood abuse to an increased risk of both perpetrating IPV in adulthood. For example, a longitudinal study of 942 adolescents (ages 12–19) in Toledo re-interviewed them a decade later (Swinford et al., 2004). The subjects were questioned on child abuse, IPV perpetration (commiting violence against a partner), and delinquency. They found that experiencing physical abuse in childhood significantly increases the likelihood of becoming a perpetrator of IPV. Similarly, another study matched 497 children (infant-11) with documented histories of physical and sexual abuse, with 397 nonabused adolescents, assessing for their experience with IPV (victimization or perpetration) in adulthood (Widom et al., 2012). They found that

individuals who experienced childhood neglect were more likely to cause injury to their partner in adulthood than controls. However, they also found that neglected individuals were more likely to experience injury and psychological abuse from their partners as adults.

This finding highlights that childhood abuse is not only a predictor of becoming a perpetrator of IPV but is also a predictor of becoming a victim of IPV, reinforcing the idea of re-victimization (Pill et al., 2017). Further supporting this trend of revictimization is an empirical study that found that out of 1,690 22-year old participants surveyed for physical and sexual abuse under 18 years and IPV after 18 years, 22.4% experienced childhood abuse, 14.5% experienced IPV, and 18.5% experienced both (Domond et al., 2023). This substantial overlap strongly supports the theory of revictimization. In a similar study with a sample of 9077 Ecuadorian women, 30% experienced either childhood physical or psychological mistreatment, 40% experienced IPV, and 38% of women who experienced both physical and psychological childhood abuse also experienced physical IPV, in comparison to 21% who did not experience childhood abuse but did experience IPV (Gómez et al., 2008). Generally, women who experienced physical or psychological childhood abuse were 1.9 times more likely to experience psychological IPV. Finally, a prospective 15-year longitudinal study of 93 girls ages 6-16 who had experienced childhood sexual abuse, found that survivors were twice as likely to experience sexual or physical IPV as adults (Barnes et al., 2009). This illustrates the strong association between childhood abuse and victimization of IPV. Therefore, the connection between childhood abuse and victimization of IPV is strongly supported; childhood abuse can prove as a predictor of IPV and increases vulnerability to future victimization.

Therefore, the various studies analyzing the relationship between childhood abuse and intimate partner violence have had inconsistent results; some have found that victims of childhood abuse are more likely to become perpetrators of IPV while others have found that they are more likely to become victims of IPV. This demonstrates a bidirectional pattern regarding the relationship between childhood abuse and IPV.

The difference in perpetration vs victimization may be attributed to gender differences. Contrary to the previously discussed studies (Gómez et al. 2008, and Barnes et al. 2009) that established that abused females are more likely to become victims of IPV, the longitudinal study from Swinford et al. (2004) found contrary results; they established that women who experienced physical abuse are actually more likely to become perpetrators of violence in intimate relationships rather than become victims of it. This trend of women who experienced childhood abuse being likely to become perpetrators was also observed in a cross-sectional study that sampled 34,653 individuals to determine their exposure to childhood abuse (including physical abuse, sexual abuse, and emotional abuse) and their experience with intimate partner violence (McMahon et al., 2015). Specifically, childhood maltreatment increased the risk of IPV perpetration by about 1.5 to 4 times. These findings suggest that gender can play a significant role on if an abused child becomes a victim or a perpetrator of IPV. However, the mixed findings and unclear results call for more research on the topic.

Therefore, childhood abuse and intimate partner violence can be compared to one another in multiple ways. Mental health outcomes were similar across both types of abuse while physical outcomes differed. Additionally, childhood abuse predicts both victimization and perpetration of IPV in adulthood,

reflecting a complex and bidirectional relationship. Gender appears to moderate these patterns, though current evidence remains mixed. Further research should aim to establish fully defined relationships considering gender through longitudinal and cross-cultural designs that account for gender, developmental timing, and the cumulative effects of trauma.

Prevention and Treatment for Abuse

Childhood Abuse Prevention

Prevention programs for childhood abuse range from school-based programs to in-home visits. However, research on the effectiveness of these programs is methodologically limited and frequently yields unclear or inconsistent results.

A systematic review of nine studies, published between 1989 and 2018, assessed school-based programs that were designed to educate children about abuse with the aim of preventing childhood maltreatment (Nyberg et al., 2021). These programs teach typically teach concepts such as safe and unsafe touches, saying no, stranger danger. Many also incorporate active participation such as roleplay, discussion, and worksheets. Short term-results (up to six months) were modestly encouraging; students demonstrated increases in self confidence, knowledge of safety skills, and understanding of abuse. However, the review could not reliably assess long-term success nor could it determine whether the school-prevention programs actually decreased the later rates of abuse. It also found that students often struggled to apply the skills they learned in real world situations.

Another cross-sectional study on school-based abuse prevention programs surveyed 137 high school students who participated in school-based abuse prevention programs in kindergarten, fourth grade, and junior high school (Ko et al., 2001). Participants were assessed on abuse knowledge, recognition skills, safety strategies, and personal abuse history. While nearly half (47.1%) had never participated in a prevention program, the study found no statistical difference between both groups in general knowledge about abuse, the ability to recognize and respond to abuse, nor the use and implementation of safety strategies. Additionally, there was a statistically significant difference in subsequent abuse rates, but only 38 students reported experiencing later abuse among both groups, limiting statistical reliability. Notwithstanding, the data is correlational, meaning there is no way of discerning whether such outcomes were the direct result of participating in prevention programs or some other factor.

Therefore, research on school-based programs is generally weak and has yielded very inconsistent results regarding successful prevention of childhood abuse; for example, while Nybers and colleagues demonstrated an increase in general knowledge of safety skills, the study from Ko et al. (2001) did not, and while Ko and colleagues (2001) did demonstrate an improvement in subsequent abuse rates as a result of the program, Nyberg and colleagues (2021) did not. Even in an ideal world in which children clearly learn, retain, and apply safety skills taught in these programs, the fundamental problem remains: abuse most often occurs in situations where vulnerable children are overpowered, intimidated, and unable to assert control regardless of what they have been taught. The common metric of how successful

participants were in learning about abuse thus is not valid for assessing how effective the program is in preventing abuse. Furthermore, the curricula of these programs disproportionately target sexual abuse, underrepresenting physical and emotional abuse despite their significance prevalence and consequences.

The second major category used for preventing childhood abuse is home visits. Home visits provide structured support during infancy or early childhood. A longitudinal empirical study by Duggan et al. (2004) randomly assigned 643 Hawaiian families into either a control group or a group exposed to the home-visitation intervention Hawaii Healthy Start program (HSP). Over the course of a year, the program targeted reductions in harmful parenting behaviors and tracked outcomes through self-reported parenting practices (including, spanking and corporal/verbal punishment among others), child hospitalizations, maternal relinquishment of the caregiving role, and CPS reports. In general, HSP had very minor and insignificant impacts iin all measured outcomes, proving its ineffectiveness in preventing child abuse.

These findings are reinforced by another review of studies of several major home-visiting programs that target children before preschool (Howard et al., 2009). The review affirmed that HSP, as well as many other home visitation programs (Healthy Families America, Comprehensive Child Development Program, Infant Health and Development Program, Early Head Start, and Early Start) display weak and inconsistent outcomes in regards to decreasing child abuse and neglect. One minor exception is Healthy Families America (HFA), which showed mild reductions in rates of physical abuse in only some states. These studies seem to suggest that though there is slight data supporting home visits, they are ultimately ineffective in decreasing child abuse.

However, not all school-based and home-visitation programs performed poorly. A systematic review of 15 empirical studies, published between 1990 and 2007 examined outcomes tied to programs for children under 5 (Reynolds et al., 2009). These studies had to assess the effects of interventions on risk factors or protective factors regarding child maltreatment. While they supported the overarching theme that early childhood interventions (whether they be school-based programs or home interventions) are not likely to significantly prevent child maltreatment, they did find two programs, out of the twelve reviewed, that showed strong evidence of maltreatment prevention. The first was Child-Parent Centers (CPCs), which is a preschool program for 3-4 year olds that takes place for half a day and provides family support services. The second program was the Nurse-Family Partnership (NFP) which implements prenatal and infancy home visits by trained nurses. The positive impact of NFP was also confirmed by the study from Howard et al. (2009). Therefore, not all hope is lost; home-intervention programs and school programs do show that they can have a positive impact if implemented correctly.

Still, in general, it is clear that current childhood abuse prevention interventions are lacking. While some interventions may offer minor improvements in parenting behaviors or children' s knowledge of abuse, the research ultimately does not reliably demonstrate reductions in actual abuse or neglect. This may reflect the inherent difficulty for healthcare workers, teachers, and various trained professionals to get to the root of a problem deeply embedded in private family dynamics. Ultimately, though improvement of interventions is possible, it will require more rigorous and reliable research and experimentation.

Treatment for IPV Trauma

Perpetrator-focused interventions generally aim to prevent future repeat perpetration. Survivor-focused treatments also try to reduce revictimization but are more focused on addressing the significant psychological consequences of IPV like depression, anxiety, PTSD, and suicidal ideation. While treatment for survivors can significantly improve survivors' mental health, research shows limited effectiveness of perpetrator and survivor-based treatment in preventing revictimization/recidivism .

A literature review of 31 studies published after 1990 analyzed intervention programs for both perpetrators and victims (Eckhardt et al., 2013). The study defined perpetrator-focused programs as batterer intervention programs (BIPs). BIPs lasted anywhere from 8 to 52 weeks and often include group discussion and activities led by counselors. Participation is often mandated through the criminal justice system. Eckhardt and colleagues (2013) emphasized the methodological weaknesses in the research available on IPV treatment for perpetrators. Most studies have small and racially disproportionate sample sizes, limited geographic diversity (with most studies conducted only in North America), lack of randomization, and inconsistent outcome measurement. Across studies, BIPs generally did not result in significant reductions in IPV perpetration. Specifically, the review heavily criticizes the Duluth model, a traditional educational model for batterers that forces their sense of accountability and responsibility. The Duluth model is rooted in feminism and in the assumption that IPV is a result of sexism, misogyny, and men's need for power over women. While cognitive-behavior interventions demonstrated slightly more positive results than the Duluth model, even these still showed limited empirical support. Therefore, both treatment types are undersupported with evidence and do not significantly decrease revictimization rates.

A more recent literature review also provides insight on the development of the BIPs (Yakeley., 2021) over time. It emphasizes that IPV rates have increased around the world in the COVID-19 pandemic and have not declined since then. This paper furthers the criticism of the traditionally and widely used Duluth model, illustrating that it ignores the possibility that females may be perpetrators, and dynamics in LGBTQ+ relationships. Additionally, the Duluth model does not focus on addressing individual past trauma, which is crucial because previous experienced childhood trauma can be linked to IPV perpetration, as previously discussed in the Comparing Childhood Abuse and IPV section. This more recent review also mentions newer interventions that are still undergoing development and research, but show promise. These include Integrated Cognitive Behavioral Intervention, which combines CBT and interpersonal therapy to address alcohol use and IPV perpetration together, and Stepping Stones and Creating Futures, which focuses on addressing IPV perpetration in relation to social and economic context, poverty, and substance misuse. Three other interventions, schema therapy, metacognitive interpersonal therapy, and mentalization-based couple therapy (MBT-CT), focus on treating personality disorder and identity issues, proving to reduce violence as well. MBT-CT in particular focuses on mutual perpetration and violence. Therefore, while perpetrator-focused treatment is still lacking and ineffective for the majority, it may be beneficial to approach the problem through different lenses that more specifically narrow in on the problems that impact people to become perpetrators in the first place (i.e,, childhood trauma, poverty, substance abuse, personality disorder).

In contrast, research on survivor-focused treatment is more developed and provides stronger evidence that such interventions reduce trauma-related mental health symptoms. Eckhardt et al. (2013)

noted that numerous types of treatment, such as cognitive-behavioral therapy, postshelter community advocacy, forgiveness-based therapy, culturally-informed empowerment groups, and social support groups, do in fact significantly improve the mental health and the quality of life of victims. Still, the literature faces two major limitations

. First, many studies did not include follow up assessments, limiting conclusions about the long-term effectiveness of these interventions. Secondly, nearly all reviewed studies assumed all victims female and all perpetrators male, overlooking the more nuanced gender dynamics of IPV described in the Comparing Childhood Abuse and IPV section. Overall, the paper concludes that the research area of IPV interventions - both for survivors and for those who use violence - remain in an early stage. Substantially more research is needed to create truly effective, accessible, and evidence-supported interventions that can meaningfully reduce rates of IPV and its mental and physical consequences.

To build on these findings, more recent research has further examined the effectiveness of psychological interventions for survivors. A systematic review of 33 papers published up until October 2019 focused on victim treatment and psychological therapies (Hameed et al., 2020). Similar to Eckhardt and colleague's paper (2013), Hameed and colleagues (2020) found that females who had undergone treatments such cognitive behavioral therapies, humanistic therapy, and third-wave behavioral treatments had a significant decrease in depressive symptoms, anxiety symptoms, and overall stress. However, consistent with Eckhard et al. (2013), these treatment still did not meaningfully prevent revictimization.

In conclusion, current IPV interventions show modest and inconsistent results. Perpetrator-focused programs, including widely used models such as Duluth, demonstrate minimal reduction of long-term recidivism. However, there is still hope in newer approaches that more directly address the underlying causes of IPV perpetration. Still, these treatments require significantly more research and development on a larger sample of people before it can be implemented widespread. On the other hand, the success of treatment for victims specifically depends on the perspective/goal of treatment: treatments are largely successful in reducing depressive or anxiety-like symptoms in women, but they are not likely to prevent revictimization.

IPV Prevention

Approaches that prevent IPV generally follow two approaches: directly targeting those most likely to perpetrate IPV in the future, or improving broader socioeconomic conditions that increase the likelihood of violence within relationships. Both pathways demonstrate potential, yet neither approach is currently sufficiently supported with enough evidence.

Logically, some may assume that the best way to prevent IPV is to focus on educating prospective perpetrators of IPV violence. A systematic review analyzed 10 empirical studies on the efficacy of specific prevention programs that targeted exclusively boys and men (Graham et al., 2019). The first study Graham and colleagues (2019) reviewed was Coaching Boys into Men (CBIM). Male high school athletes sat through 10-15 minute sessions taught by CBIM-certified athletic team coaches. At 12 months, this program did prove to yield lower IPV perpetration rates when compared to controls that did not undergo the treatment, highlighting that educational intervention can in fact influence behavior.

The rest of the programs in the review target male undergraduate students, including The Men's Program, Real Consent, Sexual Assault Prevention Program for College Men, the Men's Project, and a Video Program. These programs educate on the prevalence of sexual violence, as well as the importance of communication, consent, and empathy. The Men's Program yielded significantly lower rates of sexual abuse perpetration among fraternity members. Real Consent proved especially effective, as it was found that individuals who had undergone the program were 73% less likely to perpetrate sexual coercion than individuals who did not receive intervention. Among the less successful programs were The Sexual Assault Prevention Program for College Men, The Men's Project, and The Video Program. The Sexual Assault Prevention Program for College Men did not demonstrate a meaningful improvement, and *The Men's Project* only produced short-term positive results that had dissipated by 7 month follow up. Interestingly, the Video Program found that individuals who had gone through the program reported higher rates of sexually coercive behavior when compared to controls. Therefore, the findings on targeted perpetrator-focused programs are extremely mixed in regards to how effective they are in reducing the prevalence of IPV and improving the behavior of male youth; while some produce extremely positive and encouraging results, others produce results neutral or opposite to the desired goal.

Additionally, these programs have a shortcoming in that most are focused on preventing sexual abuse though intimate partner violence can include psychological and physical abuse, which can be more common and just as physically and psychologically damaging. Furthermore, it is crucial to recognize that by targeting only boys and men, these programs overlook the well-established fact that IPV perpetration is not exclusive to men nor limited to heterosexual relationships. While ignoring the nuanced gender complexities of IPV perpetration might make implementing the programs logistically easier, it remains a significant limitation.

A second avenue to which IPV prevention can be considered involves addressing economic stress, a powerful predictor of relationship aggression. Couples experiencing significant financial strain are three times more likely to experience aggression when compared to well-off couples (Shobe et al., 2008). Why? A need for financial security is often a reason people stay in abusive relationships; low-income women from economically disadvantaged neighbourhoods are twice as likely to experience abuse. Thus, interventions that enhance economic stability can indirectly prevent IPV by lowering relationship stress, improving financially stable options for leaving dangerous relationships, and reducing the formation of power imbalances between partners.

A literature review states that *Individual Development Accounts* (IDAs) can prevent IPV by moving people out of poverty (Shobe et al., 2008). IDAs are savings accounts for low-income individuals to help in obtaining homeownership. Participants set savings goals, receive economic education, and are matched in funds for a specific asset purchase (such as housing.) Since IDAs have traditionally been used with populations that are more likely to experience financial stress (such as people people with mental illness and immigrants), IDAs should be successfully applied to help low-income women in relationships, allowing them to easier leave a relationship should it turn abusive. But there is more than one way in which IDAs can prevent IPV: they can also help alleviate stress in the relationship of low-income couples, preventing the deterioration of the relationships. Alternatively, by targeting IDAs at individuals with a

history of IPV victimization, IDAs can prevent revictimization. Therefore, IDAs are a promising avenue that can theoretically help prevent IPV rates in multiple ways.

More recent research builds on this approach. Tankard et al. (2018) assessed cash transfer programs, a globally used poverty-reduction strategy. In this context, the most relevant cash transfer programs include Unconditional Cash Transfer (UCT) and Conditional Cash Transfer (CCT). UCTs provide cash to a household without requiring the household needing to engage in any specific activity. UCTs do reliably reduce IPV victimization. CCTs provide cash to a household contingent that the cash will be used for the wellbeing of the children's health and education. CCTs also reliably reduce both psychological and emotional IPV. Additionally, public assistance programs that support employment and workforce participation also demonstrate preventative effects on physical IPV. Ultimately, implementing government assistance to improve the financial situation of low-income couples or prospective victims can indirectly but measurably prevent IPV. Still, more expansive research is required to fortify the effectiveness of specific programs and it is important to continually and perpetually assess the effects of these government programs given that the economic and political climate is ever-changing.

Overall, both the male-focused and financial avenues of preventing IPV show potential and provide promising data, yet each possess substantial limitations. Educational programs fail in educating other demographics that can become perpetrators and disproportionately prioritize educating on sexual abuse over physical and psychological abuse. Meanwhile, economic interventions require further longitudinal research, more recent research, and ease in being consistently implemented at a large scale. Optimistically, educational and socioeconomic strategies do offer well-established and promising opportunities for improvement.

Conclusion

This paper demonstrates that two common types of trauma (childhood abuse and IPV) have profound and lasting consequences on survivors' physical and psychological well-being. Although each form of abuse occurs at different ages and under different social contexts, their long-term impacts show striking parallels. Both childhood abuse and IPV are consistently associated with psychological impacts such as depression, PTSD, and substance disorders. However, IPV's physical consequences tend to be more immediate and symptom-like, such as chronic pain, headaches, and joint problems, whereas childhood abuse is more strongly linked to diagnosable medical conditions. Both types of abuse are also inherently connected; childhood abuse meaningfully increases the likelihood of perpetrating or experiencing IPV in adulthood, reflecting a troubling intergenerational cycle of trauma.

The review discusses prevention and treatment for abuse. Generally, research examining childhood abuse prevention, victim and perpetrator-based IPV treatment, and IPV prevention remains largely disappointing, with only a few interventions producing strong results. The most consistently positive findings emerge from treatments targeting survivors' mental health; cognitive-behavioral therapy, for example, reliably reduces depression and anxiety amongst IPV victims, though does not lower revictimization rates.

Overall, the literature on IPV, childhood abuse, their long-term physical and psychological consequences, and the effectiveness of treatment and prevention efforts reveals both areas of consistency and notable methodological limitations. One of the most robust findings is the strong association between childhood abuse and declines in physical and mental health in adulthood - a pattern supported by retrospective, prospective, and longitudinal designs. Additionally, many studies demonstrate a dose-response relationship, in which greater severity and duration of abuse is liked to more significant long-term physical and psychological impacts. Taken together, these findings highlight that there exist strong patterns within the existing body of literature.

However, substantial inconsistencies in literature remain, spanning methodological limitations as well as sample and measurement limitations.

In terms of inconsistencies in methodology of current literature, longitudinal research is particularly lacking in prevention and treatment research, as long-term follow-up assessments are rarely conducted. Additionally, some studies use inconsistent definitions of abuse, making for uncertainty in interpreting results. In terms of obtaining results, few incorporate multi-method approaches that combine self-report, objective behavioral observation, and biological indicators of stress, ultimately making it difficult to discern if results are truly accurate and unbiased. Indeed, many studies provide mixed or outright contrasting results - most notably, some studies identify female victims of childhood abuse as disproportionately likely to experience future IPV victimization whereas other research finds that they are more likely to become perpetrators. Moreover, many childhood abuse prevention studies have methodological weaknesses in the metrics of results they use; success is often measured by increases in safety knowledge rather than reductions in actual victimization. Only one study included the latter metric of subsequent abuse experience rates, and while the results were promising, they were statistically limited by a small size. Thus, lacking longitudinal research, inconsistent definitions of abuse, and misguided metrics are frequently observed methodological weaknesses within current literature.

In addition to these methodological weaknesses, there is also much limitation in terms of measurement and sample variability. Few studies address male victims, female perpetrators, LGBTQ+ populations, culturally diverse families, individuals with disabilities, or seniors. These groups, while possibly experiencing abuse at especially high rates, are marginalized in research samples, limiting generalizability. Additionally, it is known that both childhood abuse and IPV can include physical abuse, sexual abuse, and/or psychological abuse. However, prevention programs and societal discussion disproportionately focus on sexual abuse. Research concerning the occurrence and outcomes of childhood abuse and IPV have the opposite problem: while it more consistently considers all subcategories of abuse, it rarely considers each type of abuse separately; in other words, outcomes usually cannot be traced to a specific subcategory of abuse (which would be valuable for prevention strategies) but rather attributed to all types comprehensively.

There are inherent challenges of researching a such a highly personal, stigmatized, and hidden topic such as IPV and childhood abuse. Self-report bias can skew studies that include surveys and/or interviews as part of their design, and participants can under or overestimate their experience of abuse simply because of how sensitive of a topic it is. To overcome these inherent challenges, IPV and childhood abuse requires future research that has robust methodology. The previously described

limitations outline future directions of research: For example, there is a need for more longitudinal research in all aspects of abuse research; this would serve to properly assess the intricacies in the development of long-term outcomes. Additionally, there is an urgent need for research on revictimization, gender's role on individual development as a victimized child matures, and the nuanced gender dynamics in abusive relationship. Investing more energy and research into under-researched groups such as the LGBTQ+ community, the disabled community, male victims, female perpetrators, culturally diverse populations, and older citizens is also needed to help ensure an unbiased and inclusive understanding of abuse. Additionally, it is important to have thorough understanding of clear and fully defined pathways and mediators between childhood abuse/IPV and later outcomes, as well as to establish more research that separates each type of abuse within the broad categories of childhood abuse and IPV: physical, sexual, and emotional abuse. There is also an urgent need for further research solidifying prevention and treatment strategies with robust methodologies because many promising existing approaches are still experimental and have not been yet implemented at scale.

Establishing this future research in all the discussed ways will help break down and understand IPV and childhood abuse from every angle. Specifically, addressing these gaps will allow treatment programs to truly address long-term impacts of IPV and childhood abuse throughout the individual´s lifetime and prevent revictimization. In terms of prevention, this research will help shift prevention strategies so they become reliably effective as well as allowing them to be focused and individualized. Including diverse populations in future samples and solidifying experimental approaches will, in turn, also improve the accessibility and awareness of treatment and prevention options. Thus, while the hidden and sensitive nature of childhood abuse and IPV greatly hinders how accurate and strong research can be, it is also the very reason that this topic needs to continually be researched. Every clarified pathway, effective intervention, or observed pattern contributes to bettering the lives of millions. The complexity and sensitivity of childhood abuse and IPV make the research difficult, but also profoundly necessary.

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