ORIGINAL ARTICLE

Childhood Abuse, Adult Intimate Partner Violence and Mental Health Outcomes: An Exploration of Cumulative Patterns of Abuse in a Subset of Studies Included in a Systematic Review

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Abstract

Purpose Research indicates that childhood abuse (CA) and later intimate partner violence (IPV) are both associated with an elevated risk of poor mental health outcomes (MHOs) in adulthood. This study reviewed data from research investigating the association of IPV with MHOs to examine the impact of CA on this relationship.

Method A narrative synthesis was employed to re-examine primary studies included in an earlier systematic review of associations between IPV exposure and MHO; 50 studies, which additionally assessed experience of CA, were retained. Evidence for the association between IPV and MHOs adjusted for CA, was systematically examined, with differences according to abuse type and population under study and impact of cumulative trauma experience explored.

Results CA was highly prevalent among IPV-exposed individuals. IPV was frequently associated with poor MHOs in the 39 studies that adjusted for CA, most obviously in community and IPV-exposed groups. Psychological IPV was linked to psychological distress and post-traumatic stress disorder severity, while physical IPV showed strong associations with depression and anxiety. Sexual IPV was independently associated with deliberate self-harm and suicidal ideation in women. CA was less consistently related to MHOs but childhood polyvictimization and experience of multiple IPV types predicted worse MHOs.

Conclusions While IPV independently impacts adulthood MHOs, cumulative abuse patterns over the lifetime, often beginning in childhood, compound the risk of poor mental health. As such, thorough assessments of abuse experiences spanning both childhood and adulthood are needed to better manage long-term and multifaceted impacts of interpersonal trauma on mental health.

Keywords Childhood abuse · Intimate partner violence (IPV) · Revictimization · Polyvictimization · Cumulative trauma · Mental health outcomes

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Introduction

Globally, it is estimated that up to 1 billion children (half of all children) aged 2–17 years, have experienced physical, sexual, or emotional violence or neglect in the past year (Hillis et al., 2016). Experiencing childhood abuse (CA) is linked to numerous negative outcomes for affected individuals, such as reduced educational and job achievement (Bunting et al., 2018; Sideli et al., 2022), worse mental health (Struck et al., 2020), somatization and overall diminished quality of life (Piontek at al., 2021). CA also carries a substantial societal cost. For example, in the United States, the annual economic impact is estimated to be between $428 billion and $2 trillion (Peterson et al., 2018). This

reflects the societal burden of CA across multiple domains, including healthcare and educational costs, criminal justice and child welfare system expenditures, lifetime productivity losses and intangible costs associated with reduced quality of life and intergenerational trauma. This underscores both the magnitude of the problem and the urgent need for early intervention, prevention strategies, and policy-level responses.

CA is among the strongest and most consistently identified preventable risk factors for developing psychiatric disorders, based on its well-established associations with a number of adverse mental health outcomes (MHOs) across a diverse range of populations (Teicher et al., 2022). Both cross-sectional retrospective studies (Aye et al., 2021; Mantovani & Smith, 2021) and longitudinal studies (Chandan et al., 2019; Strathearn et al., 2020) provide evidence for the role of CA as a precursor to mental health problems. Systematic reviews and meta-analyses have consistently found CA to be strongly associated with depression and anxiety across the life course (Baldwin et al., 2023; McKay et al., 2021), reporting an elevated risk of recurrent and persistent depressive episodes and lack of response or remission during treatment (Infurna et al., 2016; Lindert et al., 2014; Nanni et al., 2012). Notably, individuals with experience of CA, especially child emotional abuse, are more likely to have an earlier depression onset and are twice as likely to develop chronic or treatment-resistant depression (Nelson et al., 2017).

Importantly, abuse in childhood significantly raises the risk of revictimization throughout adolescence and/or adulthood (van der Feltz-Cornelis et al., 2019; Walker et al., 2019), including intimate partner violence (IPV) victimization (Bellot et al., 2024; Jennings et al., 2015; Li et al., 2019). Revictimization, at least within a broad framework, is conceptualized as experiencing two instances of interpersonal violence (sexual, physical, and/or psychological) across the life span (Corbett et al., 2023). IPV refers to behavior perpetrated against a current or former intimate partner that encompasses physical, sexual, emotional, and psychological harm, including physical violence (slapping, hitting etc.), sexual violence (coercion in sexual acts), psychological abuse (verbal insults, intimidation), and controlling behaviors that occur within a relationship (Oram et al., 2022). IPV victimization is consistently associated with numerous serious psychological and physical health consequences (Rivara et al., 2019). While women disproportionately shoulder the burden of IPV (Sardinha et al., 2022; White et al., 2024), females with adverse childhood experiences (ACEs) also appear to be at greater risk than males of interpersonal revictimization as an adult, including IPV (Papalia et al., 2021; Tian et al., 2024). This disparity is linked to a combination of gendered socialization processes,

differences in trauma coping mechanisms, and systemic power imbalances (Corbett et al., 2023; Grauerholz, 2000). Theoretical frameworks such as the traumagenic dynamics model suggest that early abuse can distort self-concept and interpersonal boundaries, potentially increasing susceptibility to further victimization (Finkelhor & Browne, 1985). Empirical research also indicates a heightened risk of developing substance-use disorders and emotion dysregulation following CA in females relative to males (Cutajar et al., 2010), which, in turn, may elevate their risk for revictimization in adulthood (Center for Substance Abuse Treatment, 2014).

Women who face abuse in childhood and experience IPV in adulthood are at a higher risk for adult mental health problems compared to those who were victimized only during childhood or adulthood, particularly symptoms of posttraumatic stress disorder (PTSD), depression, and anxiety (Classen et al., 2005; Kimerling et al., 2007). More generally, polyvictimization research, which emphasises the compounded health risks associated with experiencing multiple types of abuse or trauma over time, consistently demonstrates that the cumulative number of adverse events is more predictive of poor health outcomes than any single type of abuse or adversity (Finkelhor et al., 2007; Jakubowski et al., 2018; Lätsch et al., 2017). While early work focused on the number of adversities, research adopting a lifespan perspective has expanded this framework to include cumulative exposure to various types of abuse and adversities across the lifespan, supporting a dose-response relationship between abuse and health outcomes (Ramos et al., 2004; Yang & Hedeker, 2020). This dose-response hypothesis posits that as the number of abusive experiences increase, the number and severity of negative health outcomes also rises (Felitti et al., 1998). In one US community-based study, Scrafford et al. (2018) tested the mediating role of adulthood revictimization in the relationship between CA and current MHOs, finding that CA significantly predicted current anxiety, depression and PTSD, with adulthood revictimization mediating these effects. In a similar manner, IPV victimization partially mediated the effect of child maltreatment on self-injurious behaviors in a young community-based Canadian sample (Caron et al., 2017). This suggests that the enduring impact of CA on mental health may be partly explained by the heightened risk of chronic revictimization in adulthood. However, the cumulative dose–response relationship remains under-explored across specific populations, including IPV-exposed individuals, perinatal women, clinical psychiatric samples, and culturally diverse or non-Western populations. Most existing studies rely on community-based samples of predominantly White, cisgender adults in high-income countries, limiting the generalisability of findings. There

is a pressing need for studies that investigate how these cumulative dynamics unfold across intersectional identities and sociocultural contexts.

To effectively help people affected by IPV-related trauma, it is important to better understand how CA affects them throughout their lives and how it can lead to experiencing multiple forms of abuse and additional mental health issues. The significant detrimental effects on mental health for any type of abuse are known; however, mental health consequences may be incrementally worse for survivors experiencing multiple types of abuse, either cooccurring or compounding over a lifetime. Using data from studies investigating the association between CA and (later) IPV and MHOs, the study's objectives were:

1. To systematically review the evidence for the association between intimate partner violence (IPV) and mental health outcomes (MHOs) accounting for the role of prior child abuse (CA).
2. To examine whether and how the CA-adjusted association between IPV and MHOs differ by type of abuse and population.
3. To explore the impact of cumulative trauma experiences across the lifetime.

Method

This narrative synthesis re-examines studies included in a literature search for an earlier systematic review and meta-analysis synthesising primary data from published research papers (2012–2020) on the prevalence of lifetime and past year IPV among women, and on the associations between IPV exposure and MHOs such as depression, anxiety, PTSD, psychological distress, and suicidal ideation (White et al., 2024). We examined a subset of studies to investigate the impact of CA on individuals with experience of IPV and associated mental health problems in adulthood.

Full details regarding the review search strategy, data sources and selection of the published review can be found elsewhere (White et al., 2024). To summarise, in the original review, full-text articles were evaluated against the following criteria: (a) those that included non-military women who were 16 years or older and were assessed for IPV experiences (physical, psychological/emotional, and sexual) during their lifetime (lifetime IPV) or during the past year (i.e., 12 months prior to interview) using a validated IPV measure; (b) those which presented the results of peer-reviewed research based on quantitative methodology that provided mental health outcome data for at least one time point. The systematic review was registered on Prospero with the registration number CRD42020177744 (Mantovani et al.,

2020) and the review process followed PRISMA expanded guideline (Page et al., 2021).

Identification of Articles

The original systematic review search yielded 205 studies on IPV exposure in adults aged 16+years (201 of which included women and were ultimately included in that review), from which we identified articles that (i) measured CA (i.e., measured both CA and abuse by a partner in adulthood), and (ii) reported either (a) analysis of CA and adult MHOs or (b) analysis of IPV and MHOs with or without adjustment for CA. We first identified studies that measured CA by screening the study titles and abstracts for relevance. Then, we ran title and abstract searches using keywords (adult/hood, (re)victimization) to identify additional relevant articles. Two reviewers (JS and NM) independently reviewed the full texts of all identified articles ($n=52$) against the inclusion criteria and disagreements were discussed and resolved; 50 were retained for inclusion.

CA was defined as any deliberate acts or threats of harm committed against a child, which can be physical, sexual or emotional. As in the previous review, IPV was defined as any behavior by current or former spouses and partners that causes physical, sexual, or psychological harm. This includes acts such as physical aggression, sexual coercion, psychological abuse, and controlling behaviors, whether they occurred during a lifetime or within the past year. The selection of MHOs was based on the outcomes commonly associated with IPV in the broader literature (Bacchus et al., 2018; Dillon et al., 2013) and detailed in the original review (White et al., 2024), namely depression, anxiety, PTSD, distress, alcohol/substance misuse, self-harm and suicidality. Only studies assessing MHOs using a validated tool or a structured diagnostic interview were included.

We categorised samples as clinical, perinatal, IPV-exposed or community populations. Clinical samples included people seeking or using care from clinical services such as primary care, drug and alcohol services, and mental health services. Perinatal samples included samples of pregnant women or women in their first year postnatal. IPV-exposed samples were samples of individuals recruited on the basis of having experienced IPV. Samples from studies recruiting from nationally or regionally representative surveys, colleges or online sources were categorized as community samples.

Data Extraction

We developed a data extraction template to extract key study characteristics, including the settings, sample, country, study design, independent variables, type and timing

of assessments, statistical methods, and relevant findings (author). We also extracted more detailed information on the findings of each study, particularly relating to rates of reported CA, associations between CA and IPV, CA associations with MHOs, and IPV associations with MHOs where this was adjusted or not for CA. One reviewer (NM) extracted the details of each full-text article and another reviewer (JS) checked the extracted data to ensure consistency/accuracy in the information.

Data Synthesis

We took a narrative synthesis approach (Popay et al., 2006) to data synthesis, which was presented in table format. We summarized prevalence studies by types of CA, focusing on participant recruitment sources and type of CA experienced. We then examined studies that reported the association between CA and IPV, highlighting the magnitude of observed associations. Next, we analysed studies linking CA with MHOs, systematically organising and tabulating findings based on participant recruitment sources, CA measures, and IPV measures. Finally, we reviewed the association between IPV and MHOs in those studies that considered or controlled for the influence of CA. The findings column in Table 3 (and Supplementary Table 1) includes extracted statistics detailing these associations. For associations between IPV and MHOs, only associations that adjusted for the influence of CA were included, although these analyses frequently accounted for other potential risk factors including sociodemographic factors, partner characteristics, alcohol/substance use, socioeconomic deprivation, social support and/or (in perinatal populations) pregnancy history; these also comprised associations reported between MHOs and the frequency and/or severity of interpersonal traumatic experiences that accumulated across the lifetime (cumulative childhood abuse and adult IPV). The synthesis aimed to identify consistent evidence, assess the relationship between types of CA, IPV, and specific MHOs, and compare the consistency of findings across different statistical methods and population.

Results

Description of the Sample

Of the 50 included studies, the majority were conducted in the United States ($n=20$), with small numbers (three or fewer) conducted across 20 other countries (South Africa ($n=3$), United Kingdom ($n=3$), Spain ($n=3$), Canada ($n=2$), Australia ($n=2$), Brazil ($n=2$), Sweden ($n=2$), Austria ($n=1$), Bangladesh ($n=1$), Bolivia ($n=1$), Cameroon ($n=1$), China-Hong Kong ($n=1$), Ghana ($n=1$), Italy ($n=1$), Jordan ($n=1$), Mozambique ($n=1$), Myanmar/Burma ($n=1$), Peru ($n=1$), Tanzania ($n=1$), and Thailand ($n=1$); see Table 1). Seventeen studies recruited participants from the community (10 recruited women only), although 1 of these included only individuals with at least one traumatic event exposure in their lifetime. Thirteen studies recruited perinatal samples, 13 recruited IPV-exposed samples (9 female only and 3 male only), one of which recruited women exposed to perinatal IPV, and 7 recruited clinical samples (3 female only, 1 male only and 3 mixed). Three of these studies (2 with IPV-exposed samples and 1 clinical study of men with hypersexual disorder) also recruited a community-based or control group as a comparator. Most studies adopted surveys methods ($n=38$), the remaining were cohort studies ($n=9$) and case control studies ($n=3$).

Participants

Study sizes ranged from 64 to 34,676 participants, with a median of 567.5. Together, the studies included 92,481 participants.

Measurement of Child Abuse and Intimate Partner Violence

Studies adopted different methods and assessment tools to measure CA (see Table 1). Most of the studies used a single item question(s) (e.g., responses to a single dichotomized or ordinal) item dedicated to child abuse (CA) or individually to child sexual abuse (CSA), child physical abuse (CPA) and/or child emotional abuse (CEA), although 11 studies used the original childhood trauma questionnaire (CTQ) or the short form (CTQ-SF). Likewise, 21 different measures were used to measure IPV (see Table 1), with the revised Conflict Tactics Scales (CTS2) or the original (CTS) the most frequently used, appearing in 23 studies.

Prevalence of Child Abuse in the Included Studies

Most studies ($n=35$) reported prevalence estimates for CA or specific types of CA (Table 2). The data show consistently high rates of CSA and CPA in studies that recruited IPV-exposed samples (estimates ranged from 25 to 71%). Estimates were generally lower (but meaningful) in community and perinatal samples (with the exceptions of 2 studies which reported very high CPA estimates for community samples of women in Rwanda and Korea (Jina et al., 2012, 86%; Meekers et al., 2013, 71%) and 1 study of pregnant women in Peru (Barrios et al., 2015, CSA 32%, CPA 62%). Rates of CEA were high in studies recruiting IPV-exposed samples (range 32–78%) and female community samples

Table 1 Characteristics of included studies

First Author (Year)	Population	Sample size (% fe/male)	Measures of child abuse (CA)	Measures of intimate partner violence (IPV)	Mental health outcomes	Measures of mental health
Community-based						
1 Jina et al. (2012)	Rwandan general population	1293 100% female	CTQ-SF (modified)	WHO Multi-Country Study on Women Health and Domestic Violence Against Women	Depression & alcohol use	Center for Epidemiologic Studies Depression Scale (CES-D), Alcohol Use Disorder Identification Test (AUDIT)
2 Kaplan et al. (2012)	South African young women	2269 100% female	Single item questions	Revised Conflict Tactics Scale (CTS2)	Psychological distress	Brief Symptom Inventory (BSI-18)
3 Flair et al. (2012)	US low-income women	1438 100% female	Single item questions	Abuse Assessment Screen (AAS)	Depressive symptoms	Center for Epidemiologic Studies Depression Scale (CES-D)
4 Meekers et al. 2013	Korean national sample	10,119 100% female	Single item questions	Bolivia Demographic and Health Survey [based on the Conflict Tactics Scale (CTS)]	Depression, anxiety & symptoms of psychotic disorders	Self-Reporting Questionnaire 20 (SRQ-20), Self-Reported Questionnaire (SRQ-25)
5 Jeter & Brannon (2014)	Adolescent females from 5 countries	232 100% female	CTQ-SF	Revised Conflict Tactics Scale (CTS2), Measure of Psych-ologically Abusive Behaviors	PTSD symptoms	Posttraumatic Stress Disorder Checklist
6 Flair et al. (2015)	Arab US women	215 100% female	Single item questions	Modified version of the Abuse Assessment Screen (AAS)	Depression & PTSD	Center for Epidemiologic Studies Depression Scale short form (CESD-10), PTSD screen (PC-PTSD)
7 Ouellet-Morin et al. (2015)	US female healthcare workers	978 100% female	CTQ-SF	Conflict Tactics Scale (CTS)	Depressive disorders & psychosis spectrum symptoms	Diagnostic Interview Schedule (DIS) for DSM-IV, Michigan Alcoholism Screening Test, Drug Abuse Screening Test, Psychosis Screening Questionnaire (PSQ)
8 Al-Modal-lal (2016)	Brazilian men and women	97 100% female	Single item questions	The Safe Dates–Physical Violence Victimization Scale	Depressive symptoms & stress	Center for Epidemiologic Studies Depression (CES-D), Depression Anxiety Stress Scales
9 Liu et al. (2017)	Multi countries general population	34,676 44.6% female 55.4% male	Bespoke survey	WHO World Mental Health (WMH) surveys	PTSD	Composite International Diagnostic Interview (CIDI)
10 Alangea et al. (2018)	Chinese women	2000 100% female	Childhood trauma questionnaire (CTQ)	WHO Multi-Country Study on Women's Health and Domestic Violence Against Women	Depression	Center for Epidemiologic Studies Depression (CES-D)
11 Maru et al. (2018)	Turkish women	173 100% female	TLEQ (4 items)	Revised Conflict Tactics Scale (CTS2)	Lifetime suicidal ideation/intent	Columbia Suicide Severity Rating Scale (C-SSRS)

Table 1 (continued)

First Author (Year)	Population	Sample size (% fe/male)	Measures of child abuse (CA)	Measures of intimate partner violence (IPV)	Mental health outcomes	Measures of mental health
12 Ruiz-Perez et al. (2018)	US female caregivers	4507 51% female 49% male	Childhood trauma questionnaire short form (CTQ-SF)	WHO Multi-Country Study on Women's Health and Domestic Violence Against Women	Depression, mood disorders, PTSD, alcohol and substance abuse, suicidal ideation, & personality disorders	SF-12 questionnaire, MINI International Neuropsychiatric Interview
13 Wong et al. (2021)	Chinese college students	1015 58.5% female 41.5% male	Childhood experiences questionnaire (ACE) (1 item)	The sexual abuse subscale of the Chinese Revised Conflict Tactic Scale (CTS-2)	Anxiety & depression	Chinese version of the Hospital Anxiety and Depression Scale (HADS)
14 Wright et al. (2019)	US women (aged 24–32 years)	7392 100% female	Conflict Tactics Scale (adapted from)	Revised Conflict Tactics Scale (CTS2)	Depression & alcohol dependence	Center for Epidemiologic Studies Depression (CES-D), Alcohol Dependence from the DSM-IV
15 Ahmadabadi et al. (2020)	Australian men and women	1528 58.3% female 41/7% male	Single item	Modified version of the Composite Abuse Scale (CAS)	Depression & anxiety	Composite International Diagnostic Interview (CIDI)
16 Aye et al. (2020)	Myanmar national sample	2383 49.6% female 50.4% male	Single item	Modified version of the Conflict Tactics Scale (CTS)	Mental distress	Hopkins Symptom Checklist 10 (HSCL-10)
17 Charak et al. (2020)	UK trauma exposed sample	1051 68.4% female 31.6% male	Life events checklist (LEC-5), Childhood experiences questionnaire (ACE)	Modified version of Life Events Checklist (LEC)	Anxiety, depression & PTSD	Generalized Anxiety Disorder–7 (GAD-7), Patient Health Questionnaire-9 (PHQ-9), PTSD-Checklist for DSM-5-Civilian Version (PCL-5)

Perinatal

18 Groves et al. (2012)	South African pregnant women	1500 100% female	Single item question	WHO Multi-Country Study on Women Health and Domestic Violence Against Women	Emotional distress	Hopkins Symptom Checklist (HSCL-25)
19 Dennis and Vigod (2013)	Canadian pregnant women	166 100% female	Assessment of Inter-personal Violence and Substance Use (ALPHA)	Assessment of Interpersonal Violence and Substance Use (ALPHA)	Depressive symptoms	Edinburgh Postnatal Depression Scale (EPDS)
20 Faisal-Cury et al. (2013)	Brazilian pregnant women	701 100% female	WHO Multi-Country Study on Women's Health and Domestic Violence	WHO Multi-Country Study on Women Health and Domestic Violence Against Women	Postpartum depression	Self-Report Questionnaire (SRQ-20)
21 Barrios et al. (2015)	Peruvian pregnant women	1521 100% female	Childhood Physical and Sexual Abuse Questionnaire	WHO Multi-Country Study on Women Health and Domestic Violence Against Women	Depression symptoms	Patient Health Questionnaire depression subscale (PHQ-9)
22 Jackson et al. (2015)	US Mexican pregnant women	320 100% female	CTQ-SF (10 items)	Pregnancy Risk Assessment Monitoring System (PRAMS; Center for Disease Control, 2004)	Maternal depression symptoms & perceived stress	Edinburgh Postnatal Depression Scale (EPDS), Revised Perceived Stress Scale (PSS)

Table 1 (continued)

	First Author (Year)	Population	Sample size (% fe/male)	Measures of child abuse (CA)	Measures of intimate partner violence (IPV)	Mental health outcomes	Measures of mental health
23	Finnboga-dóttir et al. (2014)	Swedish pregnant women	1939 100% female	NorAQ	NorVold Abuse Questionaire (NorAQ) modified from the Abuse Assessment Screen (AAS)	Depression & alcohol use	The Edinburgh Postnatal Depression Scale (EPDS), Alcohol Use Disorders Identification Test (AUDIT)
24	Miller-Graff & Cheng, (2017)	US pregnant women	101 100% female	The National Women's Study PTSD Module (NWS-PTSD)	Revised Conflict Tactics Scale (CTS2)	Depressed mood, PTSD & sleep	Center for Epidemiologic Studies Depression Scale (CES-D), PTSD Checklist for DSM–5 (PCL-5), Pittsburgh Sleep Quality Index (PSQI)
25	Oliveira et al. (2017)	Brazilian post-partum women	456 100% female	THQ	Revised Conflict Tactics Scale (CTS2)	PTSD	Posttraumatic Stress Disorder Checklist–Civilian Version (PCL-C)
26	Mahenge et al. (2018)	Tanzanian postpartum women	500 100% female	Childhood experiences questionnaire (ACE)	WHO Multi-Country Study on Women Health and Domestic Violence Against Women	Postpartum depression	Patient Health Questionnaire depression subscale (PHQ-9)
27	Mandal et al. (2018)	Australian postnatal women	2621 100% female	Unspecified	Composite Abuse Scale (CAS)	Postnatal depression & anxiety	Depression, Anxiety and Stress Scale (DASS-21)
28	Ridings et al. (2018)	American female caregivers (child<5 years age)	548 100% female	Unspecified	Revised Conflict Tactics Scale (CTS2)	Depression	Beck Depression Inventory–2nd Edition (BDI-II)
20	Islam et al. (2019)	Bangladeshi married mothers	426 100% female	Single item	WHO Multi-Country Study on Women Health and Domestic Violence Against Women	Postpartum depression & postpartum suicidal ideation	Edinburgh Postnatal Depression Scale (EPDS)
30	McNaughton et al. (2020)	South African pregnant women	1480 100% female	Single item	Violence Against Women Instrument (VAWI)	Emotional distress	Hopkins Symptoms Checklist (HSCL-25)
IPV-exposed							
31	Hines et al. (2012)	US IPV help-seeking males+community control	822 100% male	Personal and Relationships Profile using items from sexual abuse history (SAH), violence socialization (VS) subscales	Revised Conflict Tactics Scales (CTS2)	Posttraumatic Stress Symptoms, Alcohol and Drug Abuse	The PTSD Checklist (PCL), Alcohol and drug abuse were measured using a scale developed for the National Women's Study
32	Sullivan et al. (2012)	US substance abuse IPV exposed women	143 100% female	Childhood trauma questionnaire (CTQ)	Conflict Tactics Scale-2 (CTS-2), Sexual Experiences Survey (SES) Psychological Maltreatment of Women Inventory (PMWI)	Depression, PTSD & alcohol problems	Center for Epidemiologic Studies Depression Scale (CES-D), Posttraumatic Stress Diagnostic Scale (PDS), Alcohol Use Disorders Identification Test (AUDIT)

Table 1 (continued)

First Author (Year)	Population	Sample size (% fe/male)	Measures of child abuse (CA)	Measures of intimate partner violence (IPV)	Mental health outcomes	Measures of mental health
33 Zacarias et al. (2012)	Mozambique IPV women	1442 100% female	4 item questions	Conflict Tactic Scales-Version 2 (CTS2), Controlling Behaviors Scale – Revised (CBS)	Depression & anxiety	Symptom Check List- Revised (SCL-90-R)
34 Jaquier et al. (2013)	US IPV women	212 100% female	Childhood trauma questionnaire (CTQ)	Conflict Tactics Scales-2 (CTS-2); Sexual Experiences Survey (SES) and Psychological Maltreatment of Women Inventory (PMWI)	Depression, PTSD & self-harm	Center for Epidemiologic Studies Depression Scale (CES-D), Posttraumatic Stress Diagnostic Scale (PDS), Deliberate Self-harm Inventory (DSHI)
35 Young-Wolff et al. (2013)	US IPV women	412 100% female	Childhood trauma questionnaire (CTQ)	Psychological Maltreatment of Women Inventory-Short version (PMWI-S), The Sexual Experiences Survey (SES), The Conflict Tactics Scale-2 (CTS-2), Past Abusive Behavior Inventory	Depression, PTSD, alcohol & drug problems	Center for Epidemiologic Studies Depression Scale (CES-D), Posttraumatic Diagnostic Scale (PDS), Alcohol Use Disorders Identification Test (AUDIT), Drug Abuse Screening Test (DAST)
36 Hines et al. (2016b)	US help seeking men	611 100% male	Personal and Relationships Profile using items from sexual abuse history (SAH), violence socialization (VS) subscales	Revised Conflict Tactics Scales (CTS2), Psychological Maltreatment of Women Inventory (PMWI)	Depression symptoms, Posttraumatic Stress Disorder Symptoms	The Center for Epidemiologic Studies Depression, The PTSD Checklist
37 Ferrari et al. (2016)	UK IPV help-seeking women	260 100% female	Single item question	Composite Abuse Scale (CAS)	Depression, anxiety, PTSD, & psychological distress symptoms	Patient Health Questionnaire Scale (PHQ-9), Generalized Anxiety Disorder Scale (GAD-7), Weathers' Posttraumatic Stress Disorder Check List, Clinical Outcomes in Routine Evaluation-Outcome Measure (CORE-OM)
38 Hines et al. (2016b)	US help seeking males	611 100% males	Personal and Relationships Profile using items from sexual abuse history (SAH), violence socialization (VS) subscales	Revised Conflict Tactics Scales (CTS2), Psychological Maltreatment of Women Inventory (PMWI)	Depression symptoms, Posttraumatic Stress Disorder Symptoms	The Center for Epidemiologic Studies Depression, The PTSD Checklist

Table 1 (continued)

First Author (Year)	Population	Sample size (% fe/male)	Measures of child abuse (CA)	Measures of intimate partner violence (IPV)	Mental health outcomes	Measures of mental health
39 Kastello et al. (2016)	US pregnant women (exposed to perinatal IPV)	239 100% female	CA History from Most Disturbing Traumatic Event (MDTE) questionnaire	Revised Conflict Tactics Scale (CTS2)	PTSD	Davidson Trauma Scale (DTS)
40 Signorelli et al. (2020)	Italian IPV help-seeking women + age-matched controls	114 100% female	Unspecified	Revised Conflict Tactics Scale (CTS-2)	Depressive symptoms & PTSD symptoms	Hamilton Depression Rating Scale (HDRS), Davidson Trauma Scale (DTS)
41 Tutty et al. (2020)	Canadian women	587 100% female	Single item	Composite Abuse Scale (CAS)	Depression, psychological distress & PTSD	The Center for Epidemiological Studies–Depression (CES-D-10), Symptom Checklist–10 (SCL-10), The PTSD Checklist
42 Wadji et al. (2022)	Dyads Cameroon	64 100% female	Childhood trauma questionnaire (CTQ)	Revised Conflict Tactics Scale (CTS-2)	Anxiety & depression	Hospital Anxiety and Depression Scale (HADS), Symptom Checklist (SCL-27+)
43 Williams et al. (2020)	US mixed online sample	230 61.7% female 34.4% male 3.9% transgender	Childhood experiences questionnaire (ACE)	Revised Conflict Tactics Scale—Victimization (CTS2). The Sexual Experiences Survey, Short Form Victimization (SES-SFV)	Depressive symptoms, PTSD symptoms & opioid misuse	The PROMIS1 Depression 8a The PTSD Checklist for DSM-5 (PCL-5) PROMIS Prescription Pain Medication Misuse 7a Scale
Clinical						
44 Gilchrist et al. (2012)	Spanish drug user women in treatment	118 100% female	Child Maltreatment History Self-report	Composite Abuse Scale (CAS)	Major depression, PTSD, self-harm/suicide attempt, borderline personality & substance use disorders	Spanish Psychiatric Research Interview for Substance and Mental Disorders (PRISM)
45 Chatzittofis et al. (2017)	Swedish hypersexual men	107 100% male	Childhood trauma questionnaire short form (CTQ-SF), Karolin-ska Interpersonal Violence Scale (KIVS)	Karolinska Interpersonal Violence Scale (KIVS)	Depressive symptoms, Active suicide plans/preparations	Montgomery–Åsberg Depression Rating Scale–Self-rating (MADRS-S), Mini-International Neuropsychiatric Interview (M.I.N.I., version 6.0)
46 Dworkin et al. (2017)	US substance abuse patients	219 49% female 51% male	The National Women's Study PTSD Module (NWS-PTSD)	The National Women's Study PTSD Module (NWS-PTSD)	PTSD	Clinician Administered PTSD Scale (CAPs)
47 Riedl et al. (2019)	Austrian patients	2031 53.2% female 46.8% male	MACE	Hurt-Insult-Threaten-Scream-Scale (HITS)	Trauma-related symptoms & psychological distress	Essen Trauma Inventory (ETI), Brief Symptom Inventory (BSI)

Table 1 (continued)

First Author (Year)	Population	Sample size (% fe/male)	Measures of child abuse (CA)	Measures of intimate partner violence (IPV)	Mental health outcomes	Measures of mental health
48 Baker et al. (2021)	US incarcerated women	112 100% female	Posttraumatic Distress Scale (PDS)	The cumulative trauma experiences (CTEs)	Depression & PTSD	Patient Health Questionnaire (PHQ-9), Post-traumatic Checklist for DSM-5 Civilian Version (PCL-5)
49 Tasa-Vinyals et al. (2020)	Spanish individuals with severe mental illness (SMI)	102 47.1% female 52.9% male	Interview	Traumatic Life Events Questionnaire (TLEQ)	PTSD & psychotic symptoms	Distressing Event Questionnaire (DEQ), Brief Psychiatric Rating Scale (BPRS)
50 Thananowan et al. 2020)	Thai women	400 100% female	Single item	Abuse Assessment Screen (AAS)	Depressive symptoms & stress	The Center for Epidemiologic Studies Depression Scale (CES-D), Thai version of Perceived Stress Scale (T-PSS–10)

(range 35–68%) although were lower in the 2 perinatal studies (11% and 26%). Prevalence of CPA and CEA in male IPV-exposed populations was comparable with their female counterparts but experience of CSA was reported less frequently in men than women in studies where rates were reported for both.

Association between child abuse and intimate partner violence in the included studies

The relationship between CA and IPV was considered in 23 studies in this review. As found elsewhere (Li et al., 2019), these studies suggested a consistent association between the CA and later IPV. Prevalence of CA (or specific types of CA) was higher in participants who experienced IPV compared with those who did not with the single exception of a nationally representative study conducted in Myanmar (Aye et al., 2020) (Table 2). Studies considering the magnitude of associations (Supplementary Table 1) indicated that CSA is an important correlate of (later) IPV, particularly in community-based (Alangea et al., 2018; Wong et al., 2021) and perinatal populations (Barrios et al., 2015). Those studies adopting a multivariate approach, which adjusted for varying factors across studies (commonly sociodemographic variables, alcohol and substance use, and personality traits), generally supported the hypothesis that IPV-exposed individuals are at increased risk of having experienced CA, independently of other factors. Further, studies with perinatal (Jackson et al., 2015), clinical (Chatzittofis et al., 2017; Thananowan et al., 2020) and IPV-exposed populations (Sullivan et al., 2012; Williams et al., 2020) reported significant associations between

severity of CA and severity of experienced IPV (correlations ranging from 0.12 to 0.46), indicative of a modest dosage effect (Supplementary Table 1).

Association Between Intimate Partner Violence and Mental Health Outcomes Adjusted for Child Abuse

Altogether, 39 studies considered CA (or CSA, CPA and/or CEA) as a covariate or controlling variable in analyses examining the association between IPV and MHOs, where one or more MHOs was the dependent variable (outcome; Table 1); 24 reported findings for depression, 7 for psychological/emotional distress, 14 for PTSD, 8 for anxiety, 2 for somatization, 3 for suicidal ideation, 1 for deliberate self-harm, 5 for alcohol-abuse/dependence, 2 for substance abuse/dependence, and 3 for other outcomes.

Of the remaining 11 studies, 2 measured bivariate associations between IPV and MHOs only (Chatzittofis et al., 2017; Tasa-Vinyals et al., 2020), 4 did not consider CA for inclusion in multivariate analyses concerning IPV and MHOs (Jackson et al., 2015; Ruiz-Pérez et al., 2018; Signorelli et al., 2020; Wright et al., 2019), 3 presented adjusted models with IPV as the only outcome (Alangea et al., 2018; Finnbogadóttir et al., 2014; Gilchrist et al., 2012), one focused only on specific items within measures of depression, anxiety and psychosis and not the total construct of each (Meekers et al., 2013) and another employed broad measures such as lifetime sexual abuse and number of traumatic events that did not necessarily include CA (although is mentioned in text below; Dworkin et al. (2017).

Table 2 Prevalence of child abuse according to type and experience of IPV

Study population First Author (Year)	IPV status	Child physical abuse	Child emotional abuse	Child sexual abuse	Child sexual and/or physical abuse	Any child abuse
Community						
Jina et al. (2012)	All	86%	39%	22%	-	-
	With IPV	89%	43%	26%		
	Without IPV	84%	34%	17%		
Kaplan et al. (2012)		17%	-	21%	-	-
Flair et al. (2012)	All	19%	-	18%	-	-
	With IPV	33%		28%		
	Without IPV	17%		17%		
Meekers et al. (2013)		71%	40%	-	-	-
Jeter & Brannon (2014)		28%	68%	-	-	-
Flair et al. (2015)	All	16%	-	21%	-	-
	With IPV	32%		32%		
	Without IPV	12%		17%		
Ouellet-Morin et al. (2015)	All					25%
	With IPV					35%
	Without IPV					18%
Al-Modallal (2016)		20%	35%	11%	-	-
Alangea et al. (2018)	All	38%	44%	27%	-	-
	With IPV	49%	53%	42%		
	Without IPV	35%	41%	23%		
Maru et al. (2018)					52%	
Wright et al. (2019)	All					20%
	With IPV					28%
	Without IPV					19%
Aye et al. (2020)	All	-	-	12%; 2% (M)	-	-
	With IPV			12%; 3% (M)		
	Without IPV			3%; 2% (M)		
Ahmadabadi et al. (2020)		-	-	13%; 4% (M)	-	-
Charak et al. (2020)		32%; 33% (M)	38%; 32% (M)	31%; 19% (M)		
Perinatal						
Groves et al. (2012)		-	-	6%	-	-
Dennis and Vigod (2013)		16%	-	16%	-	-
Faisal-Cury et al. (2013)		-	-	9%	-	-
Finnbogadóttir et al. (2014)		19%	11%	10%	-	-
Barrios et al. (2015)	All	62%	-	32%	69%	-
	With IPV				80%	
	Without IPV				63%	
Oliveira et al. (2017)				11%		
Mahenge et al. (2018)	All	33%	26%	12%	39%	49%-
	With IPV				59%	
	Without IPV				35%	
Mandal et al. (2018)						18%
Islam et al. (2019)		-	-	15%	-	-
McNaughton et al. (2020)		-	-	5%	-	-
Clinical						
Gilchrist et al. (2012)	All	57%	-	48%	71%	-
	With IPV				82%	
	Without IPV				57%	
Riedl et al. (2019)	All					35% (F+M)
	With IPV					64% (F+M)

Table 2 (continued)

Study population First Author (Year)	IPV status	Child physical abuse	Child emotional abuse	Child sexual abuse	Child sexual and/or physical abuse	Any child abuse
	Without IPV					29% (F+M)
Baker et al. (2021)		-	-	71%	-	-
Tasa-Vinyals et al. (2020)	All					47% (F+M)
	With IPV					75% (F+M)
	Without IPV					39% (F+M)
Thananowan et al. (2020)		7%	-	4%	10%	-
IPV-exposed						
Hines et al. (2012)	Exposed	47% (M)	-	-		-
	Community control	35% (M)				
Jaquier et al. (2013)		47%	60%	45%	-	
Young-Wolff et al. (2013)		71%	78%	58%	-	-
Ferrari et al. (2016)					50%	
Signorelli et al. (2020)	Exposed	25%	-	-	-	-
	Community control	2%				
Tutty et al. (2020)		-	-	55%	-	80%

Prevalence rates reflect those for female populations unless indicated by '(M)' for Male or '(F+M)' for Female and Male. Participants: postpartum women in Islam et al. (2019), Mandal et al. (2018), Mahenge et al. (2018) and Oliveira et al. (2017); pregnant women in Barrios et al. (2015), Dennis and Vigod (2013), Faisal-Cury et al. (2013), Finnbogadóttir et al. (2014), McNaughton et al. (2020), and Groves et al. (2012); women seeking medical help for drug use in Gilchrist et al. (2012); patients attending somatic hospital departments in Reidl et al. (2019); individuals with severe mental illness in Tasa-Vinyals et al. (2020); women attending gynaecological clinics in Thananowan et al. (2020); participants in Baker et al. (2021) were incarcerated women seeking treatment for trauma related to sexual victimisation

Depression and Psychological Distress

Community-based studies investigating associations with MHOs in community samples indicated that, after adjusting for individuals' (prior) experience of CA, exposure to IPV was significantly related to the risk of depressive disorder (Ahmadabadi et al., 2020; Jina et al., 2012; Ouellet-Morin et al., 2015), depression symptom severity (Al-Modallal, 2016; Flair et al., 2012, 2015; Wong et al., 2021) and psychological distress (Aye et al., 2020; Jina et al., 2012; Kaplan et al., 2012). Interestingly, in one study with Rwandan women, it was the combined experience of emotional abuse with physical and/or sexual abuse that increased the risk of depressive symptoms and psychological distress rather than independent effects of each (Jina et al., 2012). The role of CA as an independent factor in predicting depression and psychological distress varied across studies, however; 3 studies suggested both CSA and CPA were directly linked to severity of depressive symptoms or psychological distress (Kaplan et al., 2012; Flair et al., 2012, 2015) but 2 others reported nonsignificant associations (Al-Modallal, 2016; Wong et al., 2021), and in 3 instances, associations with CA were not reported (Ahmadabadi et al., 2020; Aye et al., 2020; Jina et al., 2012). One longitudinal study found experience of CA and exposure to IPV (in last 5 years) both independently increased the likelihood that women reported new-onset depression at two follow-up assessments (Ouellet-Morin et al., 2015). The authors also observed a robust additive effect, suggesting a 3-to-4-fold increase in associated risk in women who had experienced both CA and IPV. Interestingly, a similar pattern of risk emerged when considering psychosis spectrum symptoms; women exposed to either CA or IPV were at lesser risk than those who experienced both (OR=0.31, CI=0.16,0.62).

Perinatal studies examining the risk of post-partum depression reported significant effects for CA and for IPV suggesting both independently contributed to an increased risk (Mahenge et al., 2018; Mandal et al., 2018). Another found IPV (physical/sexual/psychological IPV) but not CSA increased risk (Faisal-Cury et al., 2013) while another reported a significant effect for CPA but not for CSA or any type of IPV (Dennis & Vigod, 2013). Two studies that focussed on severity of depressive symptoms suggested significant links to childhood trauma/maltreatment (Miller-Graff & Cheng, 2017; Ridings et al., 2018) but only one of these indicated that physical IPV was also uniquely associated with depression severity (Ridings et al., 2018). High levels of emotional distress during pregnancy were related to sexual IPV and psychological IPV occurring in the same period (but not physical IPV) in addition to experience of

CSA in one study (Groves et al., 2012). McNaughton Reyes et al. (2020) found that while physical/sexual IPV with a current partner was associated with distress severity at both 14-weeks and 9-months post-partum, experience of CSA only uniquely contributed to distress levels in the earlier (post-partum) period.

Studies recruiting IPV-exposed women showed positive associations between severity of IPV and risk of depression and psychological distress after controlling for CA (Ferrari et al., 2016; Tutty et al., 2020). In contrast, Zacarias et al. (2012) reported that neither experience of any type of CA or of IPV in the last year was associated with severity of depressive symptoms in a large sample of women exposed to (lifetime) IPV. In a large sample of men who experienced IPV from their female partners and sought help, sexual IPV was a stronger correlate of depression symptom severity than physical IPV, psychological IPV and abuse in childhood (Hines & Douglas, 2016a, b).

Posttraumatic Stress Disorder

The community-based studies examining PTSD symptoms presented inconsistent findings. Liu et al.'s (2017) large-scale study based on WHO World Mental Health Surveys, which considered multiple types of traumatic experiences, suggested physical IPV exposure almost doubled the associated risk of a DSM-IV diagnosis of PTSD, whereas experience of CPA was not significantly impactful. These findings supported an earlier study in which a community sample of men evidenced a positive relationship between physical IPV in the last year and PTSD symptom severity (Hines et al., 2012). However, La Flair et al.'s (2015) investigation of whether attachment insecurity moderates the association between cumulative IPV abuse and risk of PTSD among female healthcare workers indicated that both CSA and CPA independently contributed to PTSD symptom severity while recent IPV (and interaction between IPV and attachment style) did not. A study of female college students which tested a model of PTSD symptoms determined by experience of psychological abuse across developmental stages found a significant impact of CEA and psychological IPV on severity of PTSD symptoms (Jeter & Brannon, 2014).

Two studies recruiting perinatal women examined associations with PTSD symptoms using path analysis (Miller-Graff & Cheng, 2017; Oliveira et al., 2017). Miller-Graff and Cheng (2017) found that among pregnant women, there was a significant direct effect of the number of childhood trauma events on the severity of PTSD symptoms. However, they did not observe any effect from types of IPV. In contrast, Oliveira et al. (2017) found that while CSA did not have a direct effect on postpartum PTSD symptoms, both psychological and physical IPV during pregnancy were directly linked to PTSD symptoms. Additionally, CSA was directly related to psychological IPV. Interestingly, Kastello et al. (2016) observed no significant associations between PTSD risk and CA or any IPV type in a sample of pregnant women exposed to perinatal violence. In women recently experiencing IPV, frequency of experienced violence was uniquely linked to severity of PTSD symptoms in two studies (Ferrari et al., 2016; Tutty et al., 2020). Studies investigating MHOs in male survivors of IPV suggested that sexual IPV was the only significant contributor to severity of PTSD symptoms; both childhood experiences of abuse and physical IPV were non-significant correlates of symptom severity in multivariate analyses (Hines & Douglas, 2016a, b).

Anxiety/Somatization

Irrespective of participant source, most studies reported associations of moderate-to-severe anxiety and somatization with both IPV and CA, although there was inconsistency in the specific types of IPV that were most closely linked. For instance, Wong et al. (2021) investigated sexual IPV in male and female college students and found both sexual IPV and CSA experience independently contributed to the severity of anxiety and psychosomatic symptoms (after accounting for any effects of gender). Conversely, Ahmadabadi et al. (2020) reported that experience of physical IPV and psychological IPV but not sexual IPV in women at 21 years of age was linked to presence of an anxiety disorder at 30 years of age, while only psychological IPV was a significant correlate for men (parameters related to CA were not reported). Both recent IPV and (any) CA were linked to post-partum moderate-to-severe anxiety in one study (Mandal et al., 2018), whereas in a sample of women recently exposed to IPV, Zacarias et al. (2012) observed a significant association of (any) CA with severity of somatization but not with anxiety levels and (severity of) IPV was not related to either symptom type.

Suicidal Ideation/Deliberate Self-harm

Two community-based studies looked at suicidal ideation (Maru et al., 2018; Ruiz-Pérez et al., 2018), while a separate study focused on suicidal ideation in perinatal women (Islam et al., 2019). Additionally, one study examined deliberate self-harm among women exposed to IPV (Jaquier et al., 2013). Maru et al. (2018) reported that both CSA/CPA and physical/sexual IPV abuse were significant factors associated with lifetime suicidal ideation/intent among second-generation Chinese, Korean, and Vietnamese American women, but there was no effect of psychological IPV. In contrast, a study of rural South African women reported that suicidal ideation in the last month was more closely related

to psychological IPV in the past 2 years than to physical/sexual IPV, although the direct influence of CA was not reported (Jina et al., 2012). Islam et al. (2019) reported that the risk of post-partum suicidal ideation was elevated significantly in women who recently experienced physical IPV but was not related to (post-partum) sexual or psychological IPV, or to CSA. However, in a sample of women recently exposed to IPV that considered different types of IPV and CA, Jaquier et al. (2013) found that sexual IPV and CEA were most salient in differentiating between women reporting current deliberate self-harm (DSH), women reporting past DSH only and women with no DSH history.

Alcohol and Substance (ab)use

Few studies addressed alcohol or substance use disorders. Sullivan et al.'s (2012) study of risk factors for alcohol-related problems among substance-using, IPV-exposed women indicated that recent physical IPV increased the associated risk of DSM-IV diagnosed alcohol dependence by more than 50%, but severity of CA, recent sexual IPV and recent psychological IPV were not significantly related. Severity of (lifetime) IPV was the only type of interpersonal trauma directly associated with opioid misuse after controlling for other factors in a sample of men and women with a history of trauma (Williams et al., 2020).

Cumulative Abuse Across the Lifetime

A small number of studies focussed on the predictive power of the number of types of IPV (rather than directly assessing associations with severity of IPV or specific IPV types) or considered IPV (and CA) within a framework of cumulative trauma experiences across the lifetime. For example, in one study with a sample of UK adults who had screened positive for at least one traumatic event, Charak et al. (2020) reported that the lifetime total number of trauma types across childhood (CSA, CPA, CEA, neglect, witnessing IPV) and across adulthood (physical IPV, sexual IPV, assault with a weapon) were both independently associated with an increased risk of PTSD, anxiety, and depression. Similarly, Dworkin et al. (2017) found that the number of traumatic events (one of which was CPA) and lifetime history of sexual assault were associated with more severe PTSD in people seeking treatment for substance abuse treatment, although CA was not specifically investigated (this study is not included in Table 3). Two studies with IPV-exposed women that assessed the impact of multiple, repeated abuse lifetime experiences on MHOs (rather than measuring the unique impacts of CA and IPV) indicated that cumulative childhood and adult interpersonal traumatic experiences were significantly associated with severity of depressive and PTSD

symptoms (Baker et al., 2021; Young-Wolff et al., 2013). In a similar manner, Riedl et al. (2019) observed significant (positive) interactions between childhood polyvictimization (i.e. ≥4 types of CA) and IPV timeframe on a range of MHOs in a large mixed sample of hospital patients, suggesting that depression, anxiety and PTSD symptom severity were all pronounced in patients with current and/or past IPV experiences with a history of CA. However, Young-Wolff et al. (2013) observed that, compared to women with low prevalence of past (CA and IPV) abuse and low severity of current IPV, women with high prevalence of past abuse presented markedly higher levels of both alcohol and substance abuse, irrespective of current levels of IPV abuse.

Discussion

This review systematically examined evidence for the association between intimate partner violence (IPV) and mental health outcomes (MHOs), accounting for the role of prior child abuse (CA). Of the 50 studies that measured IPV, MHOs and CA, 39 considered CA as a covariate or controlling variable in analyses examining the impact of IPV on MHOs. IPV consistently emerged as a significant predictor of various MHOs in these studies – including depression, psychological distress, PTSD, anxiety, and suicidal ideation – after adjustment for CA. The nature and strength of the IPV-MHO association varied by type of abuse and population. Emotional and psychological IPV were consistently linked to psychological distress and PTSD severity, while physical IPV showed stronger associations with depression and anxiety in some populations. Sexual IPV was uniquely associated with suicidal ideation and DSH in women, and with PTSD severity in male survivors. Population differences also emerged: perinatal women more often presented with depression and PTSD associated with both IPV and CA, whereas men's MHOs were more strongly linked to IPV than to CA. Finally, cumulative trauma across the lifetime – including multiple types of CA and IPV – was significantly associated with worse MHOs, most obviously greater severity of depression, PTSD, and anxiety, and an increased likelihood of substance and alcohol misuse, reinforcing the importance of a lifespan perspective. Altogether, the findings suggest that IPV has a unique impact on MHOs with studies indicating interactive effects of IPV and CA on depressive and psychosis spectrum symptoms, underscoring the compounded mental health risks for individuals exposed to both forms of abuse. They also highlight the importance of considering abuse type and demographic characteristics in understanding IPV-MHO relationships.

Studies revealed that CA was not a consistent predictor of depression or psychological distress across populations,

Table 3 Studies investigating the association between intimate partner violence (IPV) and mental health outcomes that considered or controlled for the influence of child abuse (CA)

Study; Population	MHO measure(s)	IPV and CA measures	IPV/IPV+CA findings	CA (only) findings
Depression				
Community-based				
Jina et al., 2012; F	CES-D≥16	IPV (lifetime): WHO Study CA: CTQ (modified short)	Phys./Sex. IPV: AOR=0.6 (CI=0.3,1.1), *p*=0.071 Psyc. IPV (only): AOR=0.6 (CI=0.4,1.1), *p*=0.109 **Phys./Sex. IPV+Psyc.IPV: AOR=2.9 (CI=2.1,4.2), *p<0.001***	CA: not reported
La Flair et al. 2012; F	CES-D (severity)	IPV (past 6 months): AAS CA: Single item question(s)	**Any IPV: B=1.31 (SE=0.26), *<0.001***	**CSA: B=1.02 (SE=0.31),*p<0.01*** **CPA: B=1.04 (SE=0.31),*p*<0.01**
La Flair et al. 2015; F	CES-D (severity)	IPV (past 6 months): AAS CA: Single item question(s)	*Attachment anxiety moderation model (SEM)* IPV: B=0.26 (SE=0.29), *p>0.05* **IPV*Anxious attachment: B=0.33 (SE=0.11), *p<0.01*** *Attachment avoidance moderation model (SEM)* **IPV: B=0.73 (SE=0.28), *p<0.05*** IPV*Avoidance attachment: B=0.17 (SE=0.17), *p>0.05*	*Attachment anxiety moderation model* CSA: B=0.54 (SE=0.36), *p>0.05* CPA: B=0.20 (SE=0.42), *p>0.05* *Attachment avoidance moderation model* **CSA: B=0.21 (SE=0.01), *p<0.001*** **CPA: B=0.16 (SE=0.01), *p<0.001***
Ouellet-Morin et al., 2015; F	New-onset disorder (T2 5-year follow-up; T3 7-year follow-up): DIS	IPV (past 5 years): CTS-Form R CA: CTQ-SF (CA and/ or neglect)	**IPV (T2): AOR=1.72 (CI=1.07, 2.77), *p<0.05*** **IPV+CA (T2): AOR=3.43 (CI=1.79,6.57), *p<0.05*** **IPV (T3): AOR=1.61 (CI=1.05,2.48), *p<0.05*** **IPV+CA (T3): AOR=4.30 (CI=2.43,7.60), *p<0.05***	**CA (T2): AOR=2.01 (CI=1.25,3.22),*p<0.05*** **CA (T3): AOR=2.64 (CI=1.74,4.01),*p<0.05***
Al-Modallal, 2016; F	CES-D (severity)	IPV (lifetime): Safe Dates-PVVS CA: Single item question(s)	**Phys. IPV: β=0.31, *p=0.01*** Sex. IPV: β=0.05, *p>0.05*	CSA: β=0.18, *p>0.05* CPA: β=−0.24, *p>0.05* CEA: β=0.10, *p>0.05*;
Wong et al. 2021; M, F	HADS (severity)	Sex. IPV: CTS-2 CSA: ACE (1 item)	**Sex. IPV: b=0.94 (CI=0.32,1.56), *p=0.003***	CSA ns. in bivariate so not included in regression model
Ahmadabadi et al., 2020; M, F	MDD at 30 years old: CIDI	IPV (any ≤21 years old): CAS CSA: Single item question	Female: Phys. IPV: AOR=1.3 (CI=0.9,1.9), *p>0.05* **Sex. IPV: AOR=1.9 (CI=1.0,3.7), *p<0.05*** Psyc. IPV: AOR=1.3 (CI=0.9,2.0), *p>0.05* Male: Phys. IPV: AOR=1.0 (CI=0.6,1.8), *p>0.05* Psyc. IPV: AOR=1.1 (CI=0.6,2.1), *p>0.05*	CSA: not reported
Charak et al., 2020; M, F Trauma- exposed	PHQ-9 (mod-to-severe≥10)	No. adulthood trauma types: LEC-5 No. childhood trauma types: ACE	**Total adulthood trauma AOR=1.52 (SE=0.12), *p<0.05***	**Total childhood trauma AOR=1.36 (SE=0.18),*p<0.001***
Perinatal				
Dennis & Vigod, 2013; Post-partum	Post-partum: EPDS≥10	IPV (past, current): ALPHA CA: ALPHA (2 items)	Phys. IPV: ns Sex. IPV: ns Psyc IPV: ns	CSA: ns. **CPA: AOR=1.69 (CI=1.04,2.75),*p=0.036***
Faisal-Cury et al., 2013; Post-partum	Post-partum: SRQ-20 (≥8)	IPV: WHO Study CSA: WHO Study	**Phys./Sex. IPV: APR=1.38 (CI=1.10,1.74), *p<0.05*** **Psyc. IPV: APR=1.74 (CI=1.36,2.22), *p<0.05*** **Any IPV: APR=1.68 (CI=1.31,2.17), *p<0.05***	CSA: APR=1.01 (CI=0.72,1.42), *p>0.05*

Table 3 (continued)

Study; Population	MHO measure(s)	IPV and CA measures	IPV/IPV+CA findings	CA (only) findings
Barrios et al., 2015; Pregnant	PHQ-9≥10	IPV (last year): WHO Study CA: Childhood Physical and Sexual Abuse Quest.	IPV: significance not stated	**CSA+CPA: AOR=2.14 (CI=1.47,3.11),p<0.05**
Miller-Graff & Cheng, 2017; Pregnant	CES-D (severity)	IPV (last year): CTS-2 (severity) No. childhood trauma events: ACE	*Path analysis* Phys. IPV: b=0.03, p>0.05 Psyc. IPV: b=0.21, p>0.05 Sex. IPV: b=0.09, p>0.05	*Path analysis* **CA: b=0.21, p<0.05**
Mahenge et al., 2018; Post-partum	Post-partum: PHQ-9 (≥9)	IPV (during pregnancy): WHO Study CA: ACE	**Phys./Sex. IPV: AOR=6.1 (CI=3.28,11.35), p <0.05 Phys. IPV: AOR=5.8 (CI=2.98,11.43), p <0.05 Sex. IPV: AOR=5.5 (CI=2.52,12.09), p<0.05 IPV+Any ACE: AOR=9.10(CI=4.50,18.59), p <0.05**	**CPA: AOR=2.6 (CI=1.50,5.56),p<0.05 CSA: AOR=2.7 (CI=1.35,4.41),p<0.05 CEA: AOR=2.5 (CI=1.44,4.49),p<0.05 Any CA: AOR=5.2(CI=2.63,10.50),p <0.05**
Mandal et al., 2018; Post-partum	Post-partum: DASS-21 (Depression≥14)	IPV (last year): CAS CA: Single item question(s)	**IPV: AOR=1.8 (CI=1.0,3.0),p=0.03**	**CA: AOR=2.0 (CI=1.4,2.9),p<0.01**
Ridings et al., 2018; High-risk of CA	BDI-II (severity)	Phys. IPV: CTS-2 History of childhood maltreatment: Unspecified	**Phys. IPV: b=23.25 (CI=9.93,36.58), p =0.001**	**History of childhood maltreatment: b=4.82 (CI=2.99,6.65),p<0.001**
Clinical				
Riedl et al., 2019; M, F, Serious mental illness	BSI (severity)	IPV (current): HITS scale (adapted) No. childhood trauma types: MACE	**IPV trajectory with CA≥4 types interaction: F=3.39,p=0.006 (Post-hoc: Current IPV*CA≥4 types>IPV≥6 years ago*CA≥4 types, p=0.020)**	CA (only): not measured
Thananowan et al. 2020; Gynaecological; F	CES-D (severity)	IPV (last year): AAS (3 items) CA: Single item question(s)	*Path analysis* **IPV (severity): β=0.25, p<0.05**	*Path analysis* **CSA/CPA (severity): β=0.16,p<0.05**
IPV-exposed				
Zacarias et al., 2012; F	SCL-90-R (severity)	IPV (last year): CTS-2 CA: Single item question(s)	IPV: β=−0.03, p=0.336	CA: β=0.10, p=0.605;
Young-Wolff et al., 2013; F	CES-D (severity)	Phys. IPV: CTS-2; Sex. IPV: SES; Psyc. IPV: PMWI-S, CTS-2 (past 6 months); IPV (lifetime): ABI CA: CTQ	*Latent class analyses (cumulative CA/IPV)* **Low Cumulative (LC) IPV: M(SD)=20.1 (1.0); Low Current/High Past (LCur/HP) IPV: M(SD)=22.6 (0.8): vs. LC**p>0.05; High Cumulative (HC) IPV: M(SD)=31.2 (2.0): vs. LC p<0.001, **vs. LCur/HP p<0.001**	CA (only): not measured
Hines et al., 2016b; M	CES-D (severity)	IPV (last year): CTS-2, PMWI CA: PRP-VS	Phys. IPV (severity): β=−0.03, p=0.485 **Sex. IPV (severity): β=0.12, p=0.007** Psyc. IPV (severity): β=0.06, p=0.230	CSA (severity): β=−0.04, p=0.403 CPA (sustained and witnessed; severity): β=0.08, p=0.061
Ferrari et al., 2016; F	PHQ-9 (>9)	IPV (last year): CAS CA: Single item question	**Phys. IPV/Psyc. IPV (severity): AOR=1.02 (CI=0.99,1.05), p =0.002**	
Hines et al., 2016a); M	CES-D (severity)	IPV (last year): CTS-2, PMWI CA: SAH, PRP-VS, TEQ	Phys. IPV (severity): β=−0.03, p=0.528 **Sex. IPV (severity): β=0.12, p=0.006 Psyc. IPV (severity): β=0.09, p=0.045**	CSA (severity): ns CPA (severity): ns
Tutty et al., 2020; F	CES-D (severity)	IPV (last year): CAS CA: Single item question(s)	*MANCOVA analysis* **IPV (severity): Adjusted F=7.76, p=0.006**	*MANCOVA analysis* CA: Adjusted F=0.27, p=0.601

Table 3 (continued)

Study; Population	MHO measure(s)	IPV and CA measures	IPV/IPV+CA findings	CA (only) findings
Wadji et al. 2022; F+Control, F	SCL-27 plus (severity)	IPV (last year): CTS-2 (severity) CA: CTQ (severity)	A. **IPV exposed: IPV injuries (severity) B=−0.10, *p=0.033*** Control: IPV injuries (severity) B=3.80, *p*=0.074 B. **IPV exposed: IPV injuries (severity) B=−0.09, *p=0.044*** Control: IPV injuries (severity) B=0.29, *p*=0.180	A. **IPV exposed: CSA (severity) B=0.35,*p=0.033*** Control: CSA (severity) B=0.91, *p*=0.584 B. **IPV exposed: CEA (severity) B=0.31,*p=0.034*** Control: CEA (severity) B=−0.91, *p*=0.584
Psychological/Emotional distress *Community-based*				
Jina et al., 2012; F	CES-D (3 items; ≥3)	IPV (lifetime): WHO Study CA: CTQ (modified short)	**Phys./Sex. IPV: AOR=0.4 (CI=0.3,0.7), *p=0.001*** Psyc. IPV (only): AOR=0.8 (CI=0.5,1.2), *p*=0.227 **Phys./Sex. IPV+Psyc.IPV: AOR=1.9 (CI=1.4,2.6), *p<0.001***	CA: not reported
Kaplan et al., 2012; F	BSI-18 (severity)	IPV (last year): CTS-2 CA: Single item question(s)	**Phys. IPV (Minor) B=0.09 (SE=0.03), *p<0.01***; Phys. IPV (Severe) B=−0.04 (SE=0.04), *p*>0.05 **Sex. IPV: B=0.15 (SE=0.04), *p<0.01*** Psyc. IPV: B=0.05 (SE=0.03), *p*>0.05	**CPA: B=0.19 (SE=0.03),*p<0.01*** **CSA: B=0.20 (SE=0.02),*p<0.01***
Aye et al., 2020; M, F	HSCL-10 (severity)	IPV (lifetime): Modified CTS CSA: Single item question	Women: **IPV b=0.21 (CI=0.15,0.26), *p<0.001*** Men: **IPV b=0.18 (CI=0.12,0.24), *p<0.001***	CA: not reported
Perinatal				
Groves et al., 2012; M, F	HSCL-25 (≥44)	IPV (pregnancy); WHO Study CSA: Single item question(s)	Phys. IPV: AOR=1.17 (CI=0.99,1.38), *p*=0.063 **Sex. IPV: AOR=2.01 (CI=1.16,3.77), *p=0.014*** **Psyc. IPV: AOR=1.41 (CI=1.26,1.57), *p<0.001***	**CSA: AOR=2.84 (CI=1.71,4.70),*p<0.001***
McNaughton et al. 2020; Pregnant	HSCL-25 (*14-weeks/9-months post-partum;* severity)	IPV (current partner): VAWI CSA: Single item question	**Phys/Sex. IPV (14 weeks): b=0.19 (SE=0.07), *p<0.001*** Phys/Sex. IPV*CA (14 weeks): b=−0.24 (SE=0.15), *p*=0.12 **Phys/Sex. IPV (9 months): b=0.18 (SE=0.07), *p=0.007*** Phys/Sex. IPV*CA (9 months): b=0.10 (SE=0.16), *p*=0.53	**CA (14 weeks): b=0.14 (SE=0.07),*p=0.05*** CA (9 months): b=−0.01 (SE=0.08), *p*=0.87
IPV-exposed				
Ferrari et al., 2016; F	CORE-OM (severity)	IPV (last year): CAS CA: Single item question	**Phys. IPV/Psyc. IPV: β=0.10 (CI=0.06,0.10), *p<0.001***	CA: not reported
Tutty et al., 2020; F	SCL-10 (severity)	IPV (last year): CAS CA: Single item question(s)	*MANCOVA analysis* **IPV: Adjusted F=16.81, *p<0.001***	*MANCOVA analysis* CA: Adjusted F=0.19, *p*=0.667
PTSD *Community-based*				
Jeter et al. 2014; F	PCL-C (severity)	Psyc. IPV (current/recent relationship): MPAB CEA: CTQ-SF	**Psyc. IPV (severity) β=0.21, *p<0.001 (SEM)***	**CEA (severity) β=0.38,*p<0.001* (SEM)**

Table 3 (continued)

Study; Population	MHO measure(s)	IPV and CA measures	IPV/IPV+CA findings	CA (only) findings
La Flair et al. 2015; F	PC-PTSD (severity)	IPV (past 6 months): AAS CA: Single item question(s)	*Attachment anxiety moderation model (SEM)* IPV: B=0.15 (SE=0.11), $p > 0.05$ IPV*Anxious attachment: B=0.03 (SE=0.04), $p > 0.05$ *Attachment avoidance moderation model (SEM)* IPV: B=0.16 (SE=0.11), $p > 0.05$ IPV*Avoidance attachment: B=0.05 (SE=0.06), $p > 0.05$	*Attachment anxiety moderation model* **CSA: B=0.30 (SE=0.11),** p **< 0.01** **CPA: B=0.33 (SE=0.13),** p **< 0.05** *Attachment avoidance moderation model* **CSA: B=0.34 (SE=0.11),** p **< 0.01** **CPA: B=0.33 (SE=0.13),** p **< 0.01**
Liu et al., 2017; M, F	Disorder: CIDI	Phys. IPV (lifetime): TES CPA: TES	**Phys. IPV: AOR=1.9 (CI=1.3,2.9),** p **= 0.001**	CPA: AOR=1.5 (CI=0.9,2.5), $p > 0.05$
Charak et al., 2020; M, F Trauma-exposed	Prob-able PTSD: PCL-5 ($\geq$34)	No. of adulthood trauma: LEC-5 No. childhood trauma types: ACE	**Total adulthood trauma: AOR=1.59 (SE=0.08),** p **< 0.001**	**Total childhood trauma: AOR=1.48 (SE=0.14),** p **< 0.001**
Perinatal				
Kastello et al., 2016; M, F IPV-exposed	DTS$\geq$40	IPV (last year): CTS-2 (none, minor, severe) CA: prevalence as MDTE	Phys. IPV: ns. Sex. IPV: ns. Psyc. IPV: ns.	CA as MDTE: ns
Miller-Graff et al. 2017; Pregnant	PCL-5 (severity)	IPV (last year): CTS-2 (severity) Number of childhood trauma events: ACE	*Path analysis* Phys. IPV: b=0.08, $p > 0.05$ Psyc. IPV: b=0.16, $p > 0.05$ Sex. IPV: b=0.03, $p > 0.05$	*Path analysis* **CA: b=0.27,** p **< 0.01;**
Oliveira et al., 2017; Post-partum	Postnatal: PCL-C (severity)	IPV (pregnancy): CTS-2 CSA: THQ (3 items; $\geq$1 event)	*Path analysis* **Phys. IPV (severity): β=1.03 (CI=1.01,1.05),** p **= 0.013** **Psyc. IPV (severity): β=1.04 (CI=1.02,1.06),** p **< 0.001**	*Path analysis* CA: $p=0.066$
Clinical				
Riedl et al., 2019; M, F Serious mental illness	ETI (severity)	IPV (current): HITS scale (adapted) No. childhood trauma types: MACE	**CA$\geq$4 types interaction with IPV trajectory F=8.88,** p **< 0.001 (Post-hoc: CA$\geq$4 types x IPV 2–5 years ago > CA$\geq$4 types x IPV$\geq$6 years ago,** p **= 0.002; CA< 4 types x current IPV > CA< 4 types x IPV$\geq$6 years ago,** p **= 0.033)**	CA (only): not measured
IPV-exposed				
Hines et al. 2012; M+Community, M	PCL (severity)	Phys. IPV: CTS-2 CPA: PRP-VS	*Path analysis* Comm.: **Phys. IPV (severity) B=0.26,** p **< 0.001**	*Path analysis* Comm.: CPA ns.
Young-Wolff et al., 2013; F	PDS (severity)	Phys. IPV: CTS-2; Sex. IPV: SES; Psyc. IPV: PMWI-S, CTS-2 (past 6 months); IPV (lifetime): ABI CA: CTQ	*Latent class analyses (cumulative CA/IPV)* **Low Cumulative (LC) IPV M(SD)=15.7 (0.9); Low Current/High Past (LCur/HP) IPV M(SD)=18.0 (0.7): vs. LC** $p > 0.05$**; High** Cumulative (HC) IPV M(SD)=31.1 (1.5): vs. LC $p < 0.001$, **vs. LCur/HP** $p < 0.001$	CA (only): not measured
Hines et al. 2016b; M	PCL (severity)	IPV (last year): CTS-2, PMWI CA: PRP-VS	Phys. IPV: β=−0.02, $p=0.676$ **Sex. IPV: β=0.17,** p **< 0.001** Psyc. IPV: β=0.04, $p=0.385$	CSA: β=−0.04, $p=0.325$; CPA (sustained and witnessed): β=0.08, $p=0.067$
Ferrari et al., 2016; F	Weathers' PTSD Check List (severity)	IPV (last year): CAS CA: Single item question	**Phys. IPV/Psyc. IPV: β=0.2 (CI=0.1,0.2),** p **< 0.001; PTSD$\geq$17: AOR=1.03 (CI=1.02,1.04),** p **< 0.001**	
Hines et al. 2016a; M	PCL (severity)	IPV (last year): CTS-2, PMWI CA: SAH, PRP-VS, TEQ	Phys. IPV: β=−0.05, $p=0.337$ **Sex. IPV: β=0.15,** p **< 0.001** Psyc. IPV: β=0.08, $p=0.089$	CSA: ns. CPA: ns.

Table 3 (continued)

Study; Population	MHO measure(s)	IPV and CA measures	IPV/IPV+CA findings	CA (only) findings
Tutty et al., 2020; F	PTSD Checklist (severity)	IPV (last year): CAS CA: Single item question(s)	*MANCOVA analysis* **IPV: Adjusted F=43.69,*p<0.001***	*MANCOVA analysis* Any CA: Adjusted F=0.59, *p*=0.442
Anxiety				
Community-based				
Wong et al. 2021; M, F	HADS (severity)	Sex. IPV: CTS-2 CSA: ACE (1 item)	**Sex. IPV b=1.78 (CI=1.00,2.56),*p<0.001***	**CSA b=2.63 (CI=1.24,4.02),*p<0.001***
Ahmadabadi et al., 2020; M, F	Any Anxiety: Disorder(s) at age 30: CIDI	IPV (any≤21 years old): CAS CSA: Single item question	Female: **Phys. IPV: AOR=1.5 (CI=1.1,2.2),*p <0.05*** Sex. IPV: AOR=1.1 (CI=0.5,2.1), *p*>0.05; **Psyc. IPV: AOR=1.6 (CI=1.1,2.2),*p<0.05*** Male: Phys. IPV: AOR=1.0 (CI=0.6,1.6), *p*>0.05 **Psyc. IPV: AOR=1.9 (CI=1.1,3.1),*p<0.05***	CA: not reported
Charak et al., 2020; M, F Trauma- exposed	GAD-7 (mod-to-severe; ≥10)	No. adulthood trauma: LEC-5 No. childhood trauma types: ACE	**Total adulthood trauma AOR=1.43, (SE=0.08),*p<0.001***	**Total childhood trauma AOR=1.28 (SE=0.12),*p <0.05***
Perinatal				
Mandal et al., 2018; Post-partum	Post-partum: DASS-21 (Anxiety≥10)	IPV (last year): CAS CA: Single item question(s)	**IPV: AOR=2.6 (CI=1.6,4.3),*p<0.01***	**CA: AOR=1.7 (CI=1.1,2.5), *p=0.01***
Riedl et al., 2019; M, F Serious mental illness	BSI (severity)	IPV (current): HITS scale (adapted) No. childhood trauma types: MACE	**IPV trajectory interaction with CA≥4 types: F=4.02,*p=0.002* (Post-hoc: IPV 2–5 years ago*CA≥4 types>IPV≥6 years ago*CA≥4 types,*p=0.027*; current IPV*CA<4 types>IPV≥6 years ago*CA<4 types,*p =0.012*)**	CA (only): not measured
IPV-exposed				
Zacarias et al., 2012; F	SCL-90-R (severity)	IPV (last year): CTS-2 CA: Single item question(s)	Any IPV: β=0.05, *p*=0.126	Any CA: β=−0.03, *p*=0.196
Ferrari et al., 2016; F	GAD-7 (mod-to-severe; ≥10)	IPV (last year): CAS CA: Single item question	**Phys. IPV/Psyc. IPV (severity): AOR=1.03 (CI=1.02,1.05),*p<0.001***	
Wadji et al. 2022; F+Control, F	HADS (severity)	IPV (last year): CTS-2 (severity) CA: CTQ (severity)	**IPV exposed: Phys. IPV (severity) B=−0.02,*p =0.011*** **Control**: Phys. IPV (severity) B=0.02, *p*=0.776	**IPV exposed: CSA (severity) B=0.38,*p=0.025* Control: CSA (severity) B=1.29, *p =0.033***
Somatisation				
Community-based				
Wong et al. 2021; M, F	PHQ-15 (severity)	Sex. IPV: CTS-2 CSA: ACE (1 item)	**Sex. IPV b=1.52 (CI=0.73,2.31),*p<0.001***	**CSA b=3.43 (CI=2.03,4.83), *p<0.001***
IPV-exposed				
Zacarias et al., 2012 F	SCL-90-R (severity)	IPV (last year): CTS-2 CA: Single item question(s)	Any IPV: β=−0.03, *p*=0.430	**Any CA: β=0.10, *p<0.001***
Suicidal ideation				
Community-based				
Jina et al., 2012; F	Past month (single question)	IPV (lifetime): WHO Study CA: CTQ (modified short)	Phys./Sex. IPV: AOR=4.2 (CI=0.5,36.2), *p*=0.190 **Psyc. IPV (only): AOR=79.5 (CI=16.7,377.4), *p<0.001* Phys./Sex. IPV+Psyc. IPV: AOR=79.0 (CI=17.3,359.6), *p <0.001***	CA: not reported
Maru et al., 2018; F	C-SSRS	IPV (past 6 months): CTS-2 CA: TLEQ (4 items)	**Phys./Sex. IPV: AOR=3.28 (CI=1.26,8.55), *p =0.015*** Psyc. IPV: AOR=0.61 (CI=0.25,1.51), *p*=0.283	**CSA/CPA: AOR=3.22 (CI=1.42,7.27), *p = 0.005***

Table 3 (continued)

Study; Population	MHO measure(s)	IPV and CA measures	IPV/IPV+CA findings	CA (only) findings
Perinatal				
Islam et al. 2019; Post-partum	Post-partum: EPDS (single item)	IPV (post-partum): WHO Study CSA: Single item question	**Phys. IPV: AOR=2.65 (CI=1.36,5.18), *p* <0.01** Sex. IPV: AOR=1.18 (CI=0.55,2.54), *p*>0.05 Psyc. IPV: AOR=3.10 (CI=0.99,9.65), *p*>0.05	CSA: AOR=1.36 (CI=0.63,2.94), *p*>0.05
Deliberate self-harm				
Jaquier et al., 2013; IPV-exposed, F	Deliberate self-harm (current, past only, none): DSHI	IPV (past 6 months): Phys. IPV: CTS-2; Sex. IPV: SES; Psyc. IPV: PMWI-S CA: CTQ	*Descriptive discriminant analysis* Phys. IPV (severity): ns. **Sex. IPV (severity): F(6,414)=8.58, *p* <0.001** Psyc. IPV (severity): ns.	*Descriptive discriminant analysis* CSA (severity): ns. CPA (severity): ns. **CEA (severity): F(2,209)=16.29, *p* <0.001**
Alcohol abuse/dependence				
Community-based				
Jina et al., 2012; F	Abuse: AUDIT (≥8)	IPV (lifetime): WHO Study CA: CTQ (modified short)	Phys./Sex. IPV: AOR=6.0 (CI=1.0,36.6), *p*=0.054 Psyc. IPV (only): AOR=1.3 (CI=0.1,15.9), *p*=0.823 **Phys./Sex.IPV+Psyc.IPV: AOR=5.8 (CI=1.1,29.4), *p*=0.035**	CA: not reported
IPV-exposed				
Hines et al. 2012 M + Community, M	Intoxica- tion freq. (past year (severity)	Phys. IPV: CTS-2 CPA: PRP-VS	*Path analysis* **Comm.: Phys. IPV B=0.19, *p* <0.001**	*Path analysis* Comm.: CPA ns.
Sullivan et al., 2012; F	Abuse: AUDIT (severity)	IPV (past 3 months): CTS-2 CA: CTQ	Phys. IPV (severity): β=0.14, *p*>0.05 Sex. IPV (severity): β=−0.07, *p*>0.05 Psyc. IPV (severity): β=0.02, *p*>0.05	CA (severity): β=0.09, *p*>0.05;
Sullivan et al., 2012; F	Depen- dence: SCID (DSM-IV)	IPV (past 3 months): CTS-2 CA: CTQ	**Phys. IPV AOR=1.55, *p* <0.05** Sex. IPV: AOR=1.38, *p*>0.05 Psyc. IPV: AOR=1.00, *p*>0.05	CA AOR=5.84, *p*>0.05
Young-Wolff et al., 2013; F	Abuse: AUDIT (severity)	Phys. IPV: CTS-2; Sex. IPV: SES; Psyc. IPV: PMWI-S, CTS-2 (past 6 months); IPV (lifetime): ABI CA: CTQ	*Latent class analyses (cumulative CA/IPV)* **Low Cumulative (LC) IPV M(SD)=1.8 (0.3) Low Current/High Past (LCur/HP) IPV M(SD)=5.3 (0.5): vs. LC*p* <0.001; High Cumulative (HC) IPV M(SD)=7.9 (1.7): vs. LC *p* <0.001, vs. LCur/HP *p*>0.05**	CA (only): not measured
Substance abuse/dependence				
IPV-exposed				
Young-Wolff et al., 2013; F	Abuse: DAST (severity)	Phys. IPV: CTS-2; Sex. IPV: SES; Psyc. IPV: PMWI-S, CTS-2 (past 6 months); IPV (lifetime): ABI CA: CTQ	*Latent class analyses (cumulative CA/IPV)* **Low Cumulative (LC) IPV M(SD)=1.0 (0.2); Low Current/High Past (LCur/HP) IPV M(SD)=2.8 (0.3): vs. LC *p* <0.001; High Cumulative (HC) IPV M(SD)=5.0 (0.9): vs. LC *p* <0.001, vs. LCur/HP *p* <0.05**	CA (only): not measured
Williams et al., 2020; F	Opioid misuse: PROMIS Pain Med. (1SD>21)	IPV (lifetime): CTS-2 No childhood trauma events: ACE	**IPV (severity) AOR=1.02 (CI=1.00,1.05), *p* =0.022**	CA AOR=1.10 (CI=0.99,1.22), *p*=0.079
Other				
Community-based				
Ouellet-Morin et al., 2015; F	Psychosis (7-year follow-up): PSQ	IPV (past 5 years): CTS-Form R CA: CTQ-SF (CA and/ or neglect)	**IPV AOR=2.75 (CI=1.33,5.65), *p* <0.05 IPV+CA AOR=5.99 (CI=2.39,15.00), *p* <0.05**	**CA AOR=2.25 (CI=1.18,4.31), *p* <0.05**
Clinical				

Table 3 (continued)

Study; Population	MHO measure(s)	IPV and CA measures	IPV/IPV+CA findings	CA (only) findings
Baker et al., 2021; Incarcerated and seeking treatment for trauma related to sexual victimisation; F	Internalizing symp.: General: Depression (PHQ-9), PTSD (PCL-5), Distress tolerance (DTS); Personal: Guilt and Shame (PFQ-2)	IPV (cumulative traumatic events; CTES): PDS CSA (CTES): PDS	*SEM* **General: CTES (childhood and adult interpersonal events): β=0.25, *p =0.013* Personal: CTES (childhood and adult interpersonal events): β=0.23, *p =0.028***	CA (only): not measured
Thananowan et al. 2020; Gynaecological, F	Stress: PSS (severity)	Any IPV in past year: AAS; 3 items) CA: Single item question(s)	*Path analysis* **IPV (severity) β=0.23, *p<0.05***	*Path analysis* **CSA/CPA (severity) β=0.21, *p<0.05***

CSA childhood sexual abuse, *CPA* childhood physical abuse, *CEA* childhood emotional abuse, *Phys.* physical, *Psyc.* psychological; *Sex.* sexual, *symp.* symptom(s); Samples comprised of women only are under 'Perinatal' subheading or indicated by 'F' ('female') in the 'Study; population' column and those comprised by men only are indicated by 'M'; *B* unstandardized beta value; *β* standardized beta value; *OR* odds ratio; *AOR* adjusted odds ratio; *CI* 95% confidence interval; *SE* standard error; *ns* not significant; beta values and adjusted odds ratios are derived from multivariate linear/logistic regression unless otherwise stated. Significant differences are highlighted in bold

including the general population, pregnant women, and those exposed to IPV. In contrast, IPV consistently emerged as a significant (independent) predictor of these MHOs, particularly in community and IPV-exposed groups, highlighting the substantial role of ongoing violence in negatively affecting mental health. As noted earlier, adulthood revictimization can mediate the relationship between childhood polyvictimization and current MHOs, suggesting that the impact of CA in adulthood may at least partly result from continued abuse (Caron et al., 2017; Scrafford et al., 2018). Community studies indicated that the combination of different type of abuse - such as emotional abuse alongside physical or sexual abuse – significantly increased the risk of depression and psychological distress, while the co-occurrence of CA and IPV greatly amplified these risks. In longitudinal research, Ouellet-Morin et al. (2015) found that women exposed to both childhood and adult abuse were 4-to-7 times more likely to suffer from depression or psychosis spectrum symptoms than those without abuse histories and demonstrated a dose-response relationship between cumulative trauma and worsening MHOs. Notably, mental health difficulties also appear to increase the risk of revictimization; in longitudinal research, Auslander et al. (2018) showed that PTSD and depression fully mediated the relationship between both childhood emotional and sexual abuse and revictimization. Furthermore, strong evidence supports a bidirectional relationship between IPV and mental health problems, where IPV both predicts and results from poor mental health (White et al., 2024).

Findings on perinatal populations revealed diverse relationships between CA, IPV, and MHOs. Different forms of trauma (e.g., CSA, CPA, psychological IPV, physical IPV) had distinct effects on MHOs, with effects varying depending on the outcome being studied (e.g., depression, PTSD). Abuse occurring closer to or during pregnancy had stronger associations with perinatal depression and PTSD than did lifetime IPV exposure. Similarly, a systematic review of 47 longitudinal studies reported more consistent links between perinatal MHOs and IPV where IPV was sustained close to or during the perinatal period (Paulson, 2020). Life course theory provides a framework for understanding these patterns, emphasising the influence of timing, context, and cumulative experiences on health outcomes (Fink & Galea, 2015). Pregnancy, a period of heightened sensitivity to anxiety and depression, may amplify the effects of trauma, particularly when severe (Biaggi et al., 2016).

The relationship between CA, PTSD and IPV showed variability across studies. Community studies indicated that physical IPV was a strong predictor of PTSD, while CPA had a weaker association. In contrast, other studies showed that childhood trauma, particularly sexual or physical abuse, had a greater impact on PTSD severity in women than recent IPV. Survey data from South Africa suggested that MHOs mediate the relationship between CA and IPV in addition to being effects of IPV (Machisa et al., 2017). Emotional abuse—whether in childhood or in intimate relationships—was strongly linked to severe PTSD symptoms, suggesting a unique psychological impact. Gallagher et al. (2023) identified CEA as the primary contributor to complex PTSD, perhaps because of its covert nature, which may facilitate internalization of harm. This is broadly consistent with a growing body of neuroimaging research showing

that early exposure to maltreatment can alter trajectories of brain development and induce neurobiological alterations in regions and circuits involved with threat detection and response (Samson et al., 2024). A systematic review by Dokkedahl et al. (2022) found that psychological abuse by a partner has strong associations with PTSD, particularly coercive control in female victims, and with depression, particularly emotional and dominance-based abuse. These findings highlight the lasting mental health effects of emotional and psychological abuse.

Studies on anxiety and somatization demonstrated that both IPV and CA are associated with elevated symptoms, although the specific types of abuse showed varying degrees of impact. Sexual IPV and CSA were particularly linked to severe anxiety and psychosomatic symptoms in both male and female college students. Our synthesis also highlighted that recent IPV and CA were linked to moderate-to-severe anxiety in postpartum women, while CA was more strongly associated with somatization than anxiety in recently IPV-exposed women. As such, the findings support the strong consensus on the association between somatization and both childhood and adulthood trauma, including sexual abuse, in both men and women (Iloson et al., 2021; Waldinger et al., 2006), and with recent work demonstrating that cumulative exposure to traumatic events such as CA and/or IPV is linked to more severe somatic symptoms (Barends et al., 2022). Discrepancies across synthesized studies may reflect differences in the populations studied (postpartum women vs. recently IPV-exposed women), the outcomes measured (anxiety vs. somatization), and the type, timing, and context of trauma. Additionally, culture may be particularly relevant to the experience of somatic symptoms, underscoring the need for culturally informed approaches to understanding how IPV and CA influence somatization in adulthood (Lüönd et al., 2025).

Studies on suicidal ideation and DSH revealed that CSA, CPA, and physical or sexual IPV were significant risk factors. The combination of sexual IPV and CEA was particularly influential in determining whether IPV-exposed women were currently self-harming, had a history of self-harm, or had never self-harmed. A cross-sectional, retrospective study by Joiner Jr et al. (2007) observed that childhood physical and violent sexual abuse had stronger effects on lifetime suicide attempts than molestation and verbal abuse, with other studies identifying a 2-to-3-fold increased risk for suicide attempts and suicidal ideation in adults with histories of CA (Angelakis et al., 2019). Systematic reviews have highlighted a dose-response relationship between IPV severity and suicidality (McLaughlin et al., 2012; McManus et al., 2022), with risk increasing in those recently exposed to IPV, subjected to sexual or emotional IPV, who have suffered physical injury, and/or experiencing multiple forms of

IPV. These findings emphasise the profound mental health impact of severe and cumulative abuse, particularly physical and sexual forms of trauma.

Several studies adopted a cumulative trauma approach, examining the total number of traumatic experiences across childhood (CA) and adulthood (IPV). This approach recognises that trauma accumulates over time, with each new experience increasing the risk of adverse MHOs. Our synthesis found that individuals who experienced childhood polyvictimization combined with past or current IPV had significantly more symptoms of depression, anxiety, and PTSD. In a similar manner, although studies measuring the unique impacts of CA and IPV suggested recent physical IPV was a stronger predictor of alcohol dependence than CA (or other forms of IPV), Young-Wolff et al.'s (2013) study of cumulative exposure to multiple types of victimization showed the subgroup of women with high prevalence of past abuse more frequently presented with alcohol and substance abuse. This finding is in line with clinical studies of alcohol- and drug-using populations, which highlight that lifetime accumulation of abusive experiences, rather than IPV alone, plays a critical role in increasing the risk of substance use disorders; women with histories of multiple forms of abuse appeared particularly vulnerable to using substances, likely as a coping mechanism for enduring psychological effects (Boppre & Boyer, 2021; Lotzin et al., 2019). Previous work has demonstrated that cumulative trauma (or polyvictimization) in childhood is linked to affect dysregulation and higher dysfunctional avoidance in adulthood, which underlie 'acting out' behaviors (intended to numb or minimise the impact of negative affects) such as self-harm, suicidality, and substance abuse (Dugal et al., 2021; Briere et al., 2010). Abuse experiences over time may exacerbate the negative impacts of earlier traumas, increasing reliance on risky or maladaptive coping strategies, such as substance use (Øverup et al., 2015). Bidirectional relationships between abuse, substance use, and mental illness further amplify risks, as individuals using substances then often face higher risk of continued abuse and adversity (Center for Substance Abuse Treatment, 2014).

Our synthesis affirms the association of CA with later relational problems such as IPV and corroborates previous research demonstrating that cumulative traumatic experiences increase the risk for a wide range of psychopathological outcomes (Scott-Storey, 2011). There was marked heterogeneity across included studies with respect to the magnitude of reported associations, however. This likely reflects, at least in part, the diverse populations under study, which included communities from developing countries and immigrant communities within developed countries. Emerging research has emphasized that revictimization cannot be fully understood without considering the broader

contextual, environmental, and community-level factors that shape survivors' experiences. For instance, Corbett et al. (2023) examined how regional and rural settings in Australia contribute to the normalization of sexual violence revictimization experienced by women. Their findings suggest that geographic isolation, cultural silencing, and systemic service gaps collectively inhibit reporting and access to support, thereby reinforcing cycles of abuse. The interconnectedness of IPV revictimization with various forms of family-level inequity and power imbalance also cannot be overstated, particularly in societies with strong patriarchal foundations. Boys who are socialized via experienced violence and gender discrimination have a propensity to perpetuate the same physical violence against females in future intimate relationships (Fujiwara, 2022; Sinha et al., 2023). For individuals with a history of CA, developmental context plays a critical role in explaining both revictimization and MHOs. Previous research has demonstrated that the quality of social support in childhood has a direct effect on subsequent IPV risk; poor social support structures can exacerbate the negative effects of childhood maltreatment while strong support structures can buffer its adverse impact and foster resilience (Cascio et al., 2020; Heller et al., 1999). Complementing this, Grauerholz (2000) presents an ecological model that situates revictimization within a network of interrelated influences—including individual histories of trauma, interpersonal dynamics, and broader sociocultural norms. Together, these studies highlight the importance of adopting a multi-level perspective when examining revictimization, as the risk to individuals is often shaped and exacerbated by structural and communal factors.

Limitations

The present analysis is not without its limitations. There are drawbacks in utilising data from a previous systematic review. For instance, the last search was conducted a little time ago (November 2020), potentially missing out on pertinent studies related to the topic. Although we consider it unlikely that more recent papers would contradict our findings regarding the relationship between CA, revictimization in adulthood and MHOs, we note the finding of Zhu et al. (2024) in their meta-analysis that the reported association between CA and IPV was stronger in more recent papers. Further, we acknowledge that the exclusion of qualitative studies is a significant limitation, particularly in research concerning trauma and interpersonal violence, where the lived experiences of victim/survivors are central. The decision to focus solely on quantitative studies was based on the scope of the original systematic review we re-examined; however, we recognise that this approach risks omitting nuanced, contextualized understandings of revictimization.

In addition, the studies almost uniformly utilized retrospective recall of CA, which may be influenced by memory inaccuracies associated with recall of childhood events or possibly biased by personality traits (Reuben et al., 2016). Further, the review was dominated by studies conducted in North America and other developed countries, and as such, findings may not fully capture the intersectional dynamics of revictimization in non-Western or underrepresented populations. A key limitation in synthesising evidence is the reliance of prior research on variable-oriented approaches, which assume that samples are homogeneous or sufficiently similar to generalise findings across populations (Davies et al., 2015). These methods typically analyse multiple independent variables measuring violence at different points in both childhood and adulthood, but they vary significantly regarding the types of abuse examined, the measures used, and the samples studied (Scott-Storey, 2011). This heterogeneity likely contributes to the inconsistencies observed in the current analysis and to the observed variable impact of CA on MHOs across populations, i.e., the finding in some studies that IPV was a stronger predictor of poor mental health and the finding in others that CA played a more critical role.

Clinical implications

The findings have important implications for clinical practice. First, they emphasise the importance of comprehensive assessments of both past and recent abuse, particularly in high-risk populations. Such assessments are critical for not only understanding the origins of current mental health issues but also identifying factors that may be perpetuating these issues or may increase risk of future abuse. Differentiating whether symptoms are related to recent abuse, past abuse, or a combination of both is essential for guiding treatment decisions and tailoring the duration and focus of interventions. Adopting a life course framework is critical, as it provides a valuable lens for examining the development of psychopathology over time. This approach accounts for the accumulation and cooccurrence of experiences in different environments, the timing and severity of traumatic events, and individual vulnerabilities, all of which contribute to shaping mental health trajectories (Arévalo & Zhao, 2024).

Importantly, our study corroborates prior evidence linking CA to adult MHOs and revictimization, highlighting the importance of early intervention. Providing timely support and treatment to children exposed to violence may not only reduce their risk of developing future mental health issues but also help prevent cycles of revictimization in adulthood. By addressing these interconnected aspects of trauma and mental health, clinicians can play a pivotal role in breaking the cycle of abuse and supporting long-term recovery.

Conclusion

In conclusion, the current study highlights the high prevalence of childhood polyvictimization among individuals exposed to IPV and underscores the significant mental health burden associated with cumulative abuse experiences across the lifespan. The findings emphasise the importance of considering patterns of cumulative abuse and the role of revictimization in adulthood as a key explanatory pathway linking CA to adult MHOs. Future research should further explore these pathways to deepen understanding and inform targeted interventions. Given the significant impact of polyvictimization, clinicians are strongly encouraged to comprehensively assess patients for experiences of abuse across both childhood and adulthood to better address the complex and enduring effects of interpersonal trauma on mental health.

Declarations

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