# INTIMATE PARTNER VIOLENCE AND LIFETIME TRAUMA*

For many women, abuse by an adult partner is their first experience of victimization; for others, intimate partner violence occurs in the context of other lifetime trauma. A number of studies have begun to explore the link between histories of physical and sexual abuse in childhood and experiencing partner abuse as an adult. Women who are physically or sexually abused as children or who witness their mothers being abused appear to be at greater risk for victimization in adolescence and adulthood by both intimate and non-intimate perpetrators.[1-4 5, 6, 7, 8] And, women who experience adolescent IPV are more likely to experience IPV as adults.[9]

Studies of battered women in both clinical and shelter settings have found high rates of childhood abuse and childhood exposure to domestic violence. In a 2007 study by Kimerling et. al., women who experienced childhood physical or sexual abuse were almost 6 times more likely to experience adult physical or sexual victimization .[10] Across studies, the average reported rates of childhood physical abuse and childhood sexual abuse among women in intimate partner violence shelters or programs are 55.1% and 57.0% respectively.[11]

For women who have experienced multiple forms of victimization (e.g. childhood abuse; sexual assault; historical, cultural or refugee trauma), adult partner abuse puts them at even greater risk for developing posttraumatic mental health conditions, including substance abuse (a common method of relieving pain and coping with anxiety, depression and sleep disruption associated with current and/or past abuse). These conditions and coping strategies may, in turn, place them at risk for further abuse.[12, 13, 14, 15-21] The intersection between substance abuse and IPV is discussed in greater depth in another chapter in this textbook.

Socioeconomic factors can also expose women to victimization which compounds their risk for developing the range of mental health sequelae noted abuse. For example, low-income women (those most likely to be seen in both intimate partner violence shelters and the public mental health system) have the highest risk of being victimized throughout their lives. In one study, the lifetime prevalence of severe physical or sexual assault among very low-income women was found to be 84%; 63% of those studied had been physically assaulted as children, 40% had been sexually assaulted as children, and 60% had been physically assaulted by an intimate partner.[22] Similarly, studies conducted in welfare to work programs have documented lifetime rates of intimate partner abuse ranging from 55% to 65% [23-26], as opposed to rates of 20% found in random population samples.[27]

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A body of clinical literature describes the retraumatizing effects of more subtle forms of social and cultural victimization (e.g. microtraumatization or insidious trauma) due to gender, race, ethnicity, sexual orientation, disability and/or socioeconomic status).[28, 29-31 32, 33] Thus, although intimate partner violence itself is associated with a wide range psychological consequences, women living in disenfranchised communities face multiple sources of stress in addition to violence, including social discrimination, poorer health status and reduced access to critical resources, all of which can increase psychological distress.[34, 35] Again, many domestic violence survivors have experienced other forms of trauma, some of which may be going, that can affect their responses to current IPV.

## IPV and Mental Illness

While most survivors of domestic abuse do not develop long lasting psychiatric disabilities, mental illness appears to heighten women's risk for abuse [36, 37]. Poverty, homelessness, institutionalization, unsafe living conditions and dependence on caregivers exacerbate these risks, leaving individuals with psychiatric disabilities vulnerable to victimization by a range of perpetrators - within families, on the streets, in institutional and residential settings, and by intimate or dating partners. For example, a study of homeless women diagnosed with a serious mental illness found that a significant majority had been abused by a partner (70% had suffered physical abuse, 30.4% sexual abuse).[38] Rates of physical or sexual abuse in adulthood by any perpetrator were 87% and 76%, respectively. Intimate partner violence, itself, is often a precipitant to homelessness.[22, 39, 40] Moreover, intimate partner violence presents particular risks for individuals with serious mental illness. Exposure to ongoing abuse can exacerbate symptoms and precipitate mental health crises, making it more difficult to access resources and increasing abusers' control over their lives. Stigma associated with mental illness and clinicians' lack of knowledge about IPV, reinforce abusers' abilities to manipulate mental health issues to control their partners, undermine them in custody battles and discredit them with friends, family and the courts. In a series of focus groups conducted in Chicago, DV advocates and survivors described a number of these tactics. For example, abusers use strategies such as threatening to commit and/or committing their partners to psychiatric institutions; forcing their partners to take overdoses, which are then presented as suicide attempts, and withholding psychotropic medications. Other examples include asserting that accusations of abuse are simply delusions, lying outright about their partners' behaviors and rationalizing their own (e.g., claiming their partner "needed to be restrained"). This kind of manipulation not only increases an abuser's control over his/her partner, but also can have a chilling affect on a woman's ability to retain custody of her children, which is often one motivation behind her partner's behavior. While this type of phenomenon cuts across cultures, immigrant women who are isolated and do not speak English are particularly vulnerable to this type of abuse.[41]



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Acute symptoms of mental illness can also heighten a woman's risk for victimization. [42, 36] Although psychiatric crises are often precipitated by recent trauma, for a woman experiencing symptoms of acute psychosis, clinicians may interpret accusations of victimization as delusions, thus leaving her vulnerable to further victimization. Women may be at particular risk for assault when experiencing cognitive or emotional difficulties associated with psychotic disorders.[42] In addition, symptoms of severe trauma, such as dissociation or flashbacks, may also mimic psychotic disorders, heightening the potential for misdiagnosis and treatment that does not address underlying issues of abuse. Responses to previous trauma, such as dissociation or potentially risky coping strategies, may also increase a woman's vulnerability to abuse.[37] In addition, trauma or mental illness in childhood or adolescence can disrupt key developmental processes, leaving women without the skills they need to negotiate power and decision-making in relationships.[44] When having to manage without these skills is compounded by abuse in adulthood, the likelihood of having legitimate rights respected in any relationship may become even more remote.[45 46, 47]

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