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Childhood Interpersonal Trauma and its Repercussions in Adulthood: An Analysis of Psychological and Interpersonal Sequelae

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Abstract

Despite decades of prevention campaigns and research, childhood interpersonal trauma (i.e., psychological, physical and sexual abuse, psychological and physical neglect, witnessing interparental violence) remains an endemic problem with longstanding and deleterious negative effects on adult psycho-relational functioning. This chapter aims to present a comprehensive literature review of the repercussions associated with exposure to childhood interpersonal trauma. First, the nature and various forms of childhood interpersonal trauma are described. Subsequently, a review of the studies documenting disruptions in psychological and interpersonal functioning and the mechanisms explaining the development of each of these repercussions is unraveled. These repercussions include posttraumatic stress disorder, anxiety disorders, depression, personality disorders, affect dysregulation, substance use disorders, eating disorders, suicidal behaviors, alterations in attention and consciousness, disruptions in attributions, attachment, sexuality and violence in intimate relationships. Finally, suggestions for future research and intervention guidelines with childhood interpersonal trauma survivors are discussed.

Keywords: childhood interpersonal trauma, psychological repercussions, interpersonal repercussions

1. Introduction

Childhood exposure to maltreatment, or early interpersonal trauma, is considered as an endemic health issue with tragic personal, social and economic repercussions [1, 2]. Recent

international and US national studies show its alarming prevalence [3, 4], with 61% of children who have experienced at least one type of interpersonal trauma and more than one-third who report two or more additional types of interpersonal violence. Moreover, numerous studies have shown that exposure to interpersonal trauma during childhood can chronically and pervasively alter social, psychological, and cognitive development [5, 6]. Indeed, childhood interpersonal trauma is associated with a plethora of serious short-term [7, 8] and life-long consequences [9] such as impaired physical and mental health, increased incidence of affect dysregulation, alterations in attention and consciousness, identity impairments, and interpersonal difficulties [10, 1, 4]. In the past few years, this area of research has expanded from depictions of the prevalence of interpersonal trauma in various populations to the documentation of its possible repercussions, and identification of risk and protective factors that contribute to adaptation or lack thereof in the wake of early interpersonal trauma [11].

This chapter aims to present a comprehensive narrative literature review of the repercussions associated with exposure to childhood interpersonal trauma. First, the nature and different forms of childhood maltreatment will be described. Subsequently, a review of the studies documenting disruptions in psychological and interpersonal functioning and the mechanisms explaining the development of each of these repercussions will be unraveled. This review was conducted using two different strategies. First, pertinent keywords in various combinations (e.g., “childhood interpersonal trauma” AND “effects” OR “repercussions”; “child interpersonal maltreatment” AND “personality disorders” OR “psychological disorders” OR “post-traumatic stress disorder”; “childhood maltreatment” AND “interpersonal relationships”; “child abuse” AND “attachment”) were used to search PsycINFO and PubMed databases, up to January 2016, for relevant English or French language peer-reviewed articles and books. Subsequently, the references of the identified articles and chapters were examined to find additional pertinent papers. In accordance with the results of the research conducted, the childhood interpersonal trauma aftereffects that will be addressed in this chapter include posttraumatic stress disorder, anxiety disorders, depression, personality disorders, affect dysregulation, substance use disorders, eating disorders, suicidal behaviors, alterations in attention and consciousness, disruptions in attributions, attachment, sexuality and violence in intimate relationships.

2. Childhood interpersonal trauma

Psychological, physical, and sexual abuse, neglect, and witnessing interparental violence before 18 years of age consist of different forms of childhood interpersonal trauma as they result in actual or potential harm to a child’s health, survival, development, or dignity in the context of a relationship of responsibility, trust, or power [4]. According to Briere [12], childhood interpersonal trauma can be divided into two categories: acts of omission and acts of commission. Acts of omission refer to the incapacity or refusal of caregivers to adopt interpersonal behaviors essential to the development of a child, such as sustained responsiveness and availability, so that he or she is deprived of care, support, and psychological stimulation [12, 13]. Acts of omission include both psychological and physical neglect. Psychological

neglect is defined as the experience of having been ignored or not felt loved nor understood by a caregiver. Physical neglect is defined as not having received regular meals, baths, clean clothes, needed medical attention or having been confined in a room alone for extended periods of time [14]. According to a recent meta-analysis [15], psychological neglect is reported by 18% of the general population and physical neglect by 16%.

Unlike acts of omission, acts of commission involve abusive behaviors such as psychological, physical, or sexual abuse directed toward the child [12]. Psychological abuse describes the repeated experience of humiliation, blame, criticism, rejection, threats, or insults from the caregiver [16]. This form of abuse affects 36–46% of the general population [17, 18]. Physical abuse refers to the experience of physical contacts or constraints perpetrated with the intention of injuring the child. These abusive acts include punching, kicking, slapping, shoving, pushing, and beating with an object [19]. In the general population, 31–42% of men and 21–33% of women report having sustained physical abuse during childhood [17, 18]. According to Canada's legal dispositions, sexual abuse is defined as any sexual contact between a child under 16 years of age and a person at least 5 years older [20]. North American prevalence rates for childhood sexual abuse exhibit considerable variability across studies but tend to confirm that 10% of men and 20% of women report this type of interpersonal trauma [21]. Another form of childhood interpersonal trauma is being exposed to interparental violence. In 2007, according to the *Youth Protection Act*, exposure to interparental violence has been added to the reasons compromising a child's development [22]. Specifically, exposure to this kind of violence is defined as the observation, between the parents or parental figures, of physical aggression, sexual coercion, psychological harassment, or more general constraint or coercion [23]. Data from the *Canadian Incidence Study of Reported Child Abuse and Neglect* indicate that up to 26% of children are exposed to psychological or physical interparental violence [22].

Interestingly, early interpersonal trauma not only produces compelling and long-lasting psychological and relational maladjustment, but it is also related to a greater probability of sustaining additional interpersonal trauma during childhood and later in life. This vulnerability is referred to as *revictimization* [24, 25]. Substantial evidence suggests that individuals exposed to one category of interpersonal trauma during childhood are also likely to have experienced other types of victimization [26]. Research increasingly points to the experience of multiple types of interpersonal trauma, referred to as *polyvictimization* [3, 27, 28] and *cumulative trauma* [29]. Some researchers also refer to this phenomenon as *complex childhood trauma* since it encompasses exposure to multiple, often prolonged or extended developmentally adverse traumatic events that occur early in life [5, 24, 30]. Typically, these constructs refer to the experience of some combination of psychological, physical, and sexual abuse, psychological and physical neglect, and exposure to interparental violence and are operationalized as the total number of different types of interpersonal victimization experienced by a given individual [8, 17, 10, 31].

Studies are generally consistent in finding that experiencing multiple types of childhood interpersonal trauma may be particularly detrimental since it is related to more severe and complex psychological and relational consequences, both in childhood and adulthood, when compared to exposure to a single type of interpersonal trauma [8, 10, 32–34]. Indeed, cumu-

lative or complex interpersonal trauma not only increases the risk of posttraumatic stress symptoms but can also result in an intricate pattern of psycho-relational symptoms [24].

3. Repercussions of childhood interpersonal trauma

Childhood interpersonal trauma can have a detrimental impact on a child's development, especially regarding psychological and interpersonal functioning [35, 36]. Their potentially adverse consequences on the psychological sphere are manifold: increased risk of depression, anxiety, posttraumatic stress symptoms, aggression, dissociation, substance use, risky sexual behaviors, as well as borderline, antisocial, schizotypal, avoidant, and schizoid personality disorders [37–41]. In the long run, these psychological repercussions may take a chronic course and lead to high rates of suicidality and low levels of social functioning [42, 43].

3.1. Psychological repercussions of childhood interpersonal trauma

Research has consistently shown that some traumatic events are more symptom-producing and cause greater distress and posttraumatic aftereffects than others [10]. For instance, childhood interpersonal trauma, especially cumulative trauma, is the form of traumatic event that is the most strongly associated with later difficulties because of its effects on psycho-relational health and child development [10, 13, 24]. Indeed, childhood interpersonal trauma is associated with increased risk of mental health problems throughout the lifespan [44], including posttraumatic stress, eating disorders [45], depression, anxiety, suicidality, and substance use [24, 46]. Ultimately, these psychological problems may take a chronic course and lead to low levels of relational and professional functioning, higher rates of suicidality and less active social participation [40, 42, 43]. Moreover, there appears to be a cumulative effect of exposure to trauma during childhood with the risk of psychological, physical, and relational health problems increasing as the number of different types of victimization experienced increases [31, 44, 47, 48]. Thereby, a clear understanding of the most common forms of psychological impairment in adult survivors of early interpersonal trauma is deemed necessary.

3.1.1. Posttraumatic stress disorder

Posttraumatic stress disorder is highly prevalent in adult survivors of childhood interpersonal trauma [40, 49–52] especially since interpersonal trauma represents the form of traumatic experiences that induces the highest rates of posttraumatic symptoms [44, 53].

According to several authors [12, 40, 50, 53], the propensity to develop posttraumatic stress symptoms depends on many factors such as one's temperament, the number of different types of interpersonal trauma experienced, pre-existing psychological difficulties, biological vulnerabilities to stress, or exposure to previous traumatic events. For instance, gender, age, socioeconomic status, the presence of psychological dysfunctions or disorders, family dysfunctions or psychopathology history, previous trauma exposure, peritraumatic dissociation,

and the interaction between genetic predispositions and environmental stress may influence a victim's risk of developing posttraumatic symptoms [24]. According to Briere [12], an individual's reaction to a traumatic event would thus be contingent on the degree to which the stressor overwhelms this person's ability to manage its repercussions. Yet, characteristics specific to the traumatic events can also shape a victim's trajectory from early interpersonal trauma to posttraumatic stress symptoms such as the presence of life threat, sexual victimization, physical injury, or trauma of longer duration or greater frequency [24].

Researchers have highlighted a significant proportion of survivors who present complex posttraumatic stress, which describes difficulties arising from severe, profound, and repeated interpersonal trauma beginning in childhood [24]. Thus, early interpersonal trauma survivors tend to present more complex psychological difficulties that might not only involve posttraumatic stress symptoms, but also disturbances in self-organization [54], borderline personality disorder [55], major depression, substance abuse/dependence, simple phobia, social phobia, and agoraphobia [56]. Indeed, posttraumatic stress disorder rarely occurs alone, with up to 80% of those diagnosed with this disorder also presenting at least one other psychological disorder [56].

3.1.2. Anxiety disorders

Anxiety disorders are the most common category of diagnoses. Approximately 29% of the US population is estimated to have or to have had one or more diagnosable anxiety disorders at some point in their lives (see [57]). Empirical results reveal that childhood interpersonal trauma is associated with the presence and severity of anxiety disorders (for a review see [58–60]). Indeed, results of a longitudinal study conducted in New Zealand revealed that generalized anxiety disorder was associated with physical abuse and sexual abuse during childhood [61].

Contemporary theories and empirical research provide interesting developmental models of anxiety disorders in adulthood. According to learning theories, early experiences act as vulnerability factors that can considerably affect the psychological consequences of traumatic life events often implicated in the origins of anxiety disorders [62]. Such early learning, along with temperamental vulnerabilities, can serve as diatheses that make certain individuals more susceptible to adverse and stressful experiences that sometimes lead to the development of anxiety disorders. That is, people who have a history of uncontrollable and unpredictable life stressors (e.g., childhood interpersonal trauma) are more likely to develop anxiety disorders [62]. Certain cognitions and behaviors may serve as an attempt to suppress, control, or avoid trauma-related anxiety, but those avoidance mechanisms may lead to more negative intrusive thoughts or perceptions of uncontrollability, which are, in turn, associated with greater anxiety, leading to a vicious cycle [62, 63].

Childhood interpersonal trauma has also been linked to an increased likelihood of developing social phobia [64, 65] and panic disorder [66]. Conditioning theory is a useful model to understand the onset of social phobias. Indeed, several features of conditioning events themselves have a strong impact on how much fear is acquired. For example, having control

over a traumatic event (such as being able to escape) has a major impact on how much fear is conditioned to the trauma-related stimuli. Far less fear is conditioned when the aversive event is escapable than when it is inescapable [62]. When it comes to childhood interpersonal trauma, the possibility to escape is lessened since the perpetrator is often a caregiver. This specificity might have a crucial impact on how much fear is experienced, acquired, or maintained over time and to what extent, over the long haul, people, places, and situations reminiscent of the trauma will be avoided by the survivor. In the same vein, prior learning experiences that lead to perceptions of lack of control and helplessness such as interpersonal trauma may serve as psychological vulnerability factors influencing the development of panic disorder and agoraphobia [67].

3.1.3. Depression

Substantial evidence from both cross-sectional and prospective studies indicates that childhood interpersonal trauma is a robust predictor of the development of clinical depression in different samples of adults [68–73]. Indeed, those who have been exposed to trauma are at risk of developing major depressive disorder, especially since depression is one of the most common comorbid disorders for posttraumatic stress disorder [53, 74]. Moreover, research shows a strong association between the number of traumatic events experienced during childhood and mental health problems, including depression, in adulthood [75, 76]. For example, results indicate that childhood interpersonal trauma survivors are two to four times more at risk for depression when compared to non-survivors [48, 77]. Finally, a recent meta-analysis on the associations between different childhood experiences of interpersonal trauma and major depression reveals that psychological abuse is the strongest predictor for later depression compared to other forms of interpersonal trauma [78].

3.1.4. Personality disorders

According to the DSM-5 [79], personality disorders are defined as inflexible, pervasive, and enduring patterns of inner experience and behavior that lead to clinically significant distress or impairment in social, occupational, or other important areas of functioning. Despite the lack of knowledge as to the precise development of personality disorders, there is a consensus in the actual scientific literature that personality disorders result from the combination of a variety of biological, temperamental, developmental, and environmental influences [80]. For instance, according to the diathesis-stress model [81], antisocial personality disorder would arise from certain genetic vulnerabilities, which lead to problematic behaviors in childhood that are aggravated by high-risk environments [82, 83]. As such, early environmental factors such as childhood interpersonal trauma, disrupted family bonds, and externalizing behavioral problems (including aggression and bullying) could act as risk factors for antisocial personality disorder [82, 84].

Borderline personality disorder would also emanate from a combination of biological and environmental mechanisms, the latter of which would include social and attachment-related disturbances [85]. In her biosocial model, Linehan [86] puts forward a transactional approach to borderline personality disorder, which is conceptualized as the result of an individual's

biological predisposition to emotion regulation difficulties and an invalidating rearing environment. Therefore, the development of borderline personality disorder would be due to lack of responsiveness and proximity from relevant caregivers, which would subsequently disrupt the ability to effectively regulate emotions [85, 87]. As it happens, such caregiving shortcomings commonly characterize early interpersonal trauma survivors [85]. Consistent with these theoretical perspectives, there is a robust body of literature indicating an association between borderline personality disorder and a history of neglect, and of physical, sexual and psychological abuse as well as the cumulative experience of several forms of childhood interpersonal trauma [55]. Precisely, between 30 and 90% of individuals diagnosed with borderline personality disorder report having sustained childhood sexual, physical, or psychological abuse [88–90].

Although the association between childhood interpersonal trauma and borderline personality disorder is quite substantial, less attention has been paid to other types of personality disorders in trauma survivors [91], even though clinical and populational studies have both shown personality disorders to be more prevalent among adults who have experienced childhood interpersonal trauma than among those who have not [92–95]. In addition, the scientific knowledge on the links between trauma types and specific personality disorders is compounded due to the frequent co-occurrence of different types of early interpersonal trauma and the high comorbidity between personality disorders [41]. As of now, only a few researchers have tried to pinpoint these trauma-personality disorder associations. In a recent study, Lobbstaël et al. [94] investigated the relationships between five types of childhood interpersonal trauma and 10 personality disorders as described in the DSM-IV. According to the results of this study, sexual abuse was associated with paranoid, schizoid, borderline, and avoidant personality disorders; physical abuse was related to antisocial personality disorder; psychological abuse showed significant associations with paranoid, schizotypal, borderline, avoidant, dependent, and obsessive-compulsive personality disorders; and psychological neglect was associated with histrionic and borderline personality disorders. Similarly, in a psychiatric sample, Cohen et al. [93] provided support for independent relationships between physical abuse and antisocial traits; psychological abuse and avoidant, dependent, and obsessive-compulsive personality disorders; and neglect and paranoid, schizoid, and schizotypal personality disorders. Finally, Waxman et al. [41] identified specific associations between borderline and schizotypal personality disorders with a history of child sexual abuse (CSA), antisocial personality disorder with child physical abuse. They also found an association between avoidant and schizoid personality disorders and psychological neglect.

Nonetheless, even if studies are consistent in finding that interpersonal trauma commonly increases the risk for adult personality disorders, the specific associations between different types of interpersonal trauma and personality disorders still remain poorly understood. Future studies should thus pursue the exploration of distinct trauma-personality disorder associations as well as relationships between the co-occurrence of multiples types of early interpersonal trauma and subsequent personality disorders.

3.1.5. *Affect dysregulation*

An overarching negative repercussion of childhood interpersonal trauma is affect dysregulation. Affect regulation refers to an individual's capacity to control and tolerate strong and negative emotions without resorting to avoidance strategies that distract, soothe, or draw attention away from emotional distress [12]. Specifically, affect regulation can be conceptualized as a multidimensional construct [96], comprised of a cognitive and a behavioral dimension [97]. The cognitive dimension of emotion regulation is based on the regulation of affects and refers to the inhibition of mood swings or of the expression of anger. The behavioral dimension of emotion regulation is reflected by the ability to refrain from externalizing negative emotions through avoidance or dysfunctional behaviors [98]. These behavioral strategies manifest as tension reduction behaviors, the most common of which are self-destructive behaviors, binge/purge eating, impulsivity, as well as aggressive and risky sexual behaviors [98]. Indeed, up to 79% of those who self-harm report histories of childhood interpersonal trauma [99].

Researchers have suggested that, by its premature and severe nature, childhood interpersonal trauma would not only interrupt normal child development and associate negative affect to trauma-related stimuli, but would also interfere with the development of essential regulation skills [10]. As such, the experience of interpersonal trauma during childhood may impede the development of adaptive affect regulation by exposing children to overwhelming or extreme emotional demands while simultaneously failing to teach them how to regulate emotional arousal, to control their behaviors in the context of emotional arousal or to tolerate emotional distress [100]. Consequently, when faced with insufficient affect regulation skills or overwhelming negative emotions, adult survivors of childhood interpersonal trauma are often unable to cope and tend to resort to avoidance strategies to numb or reduce the impact and duration of experienced negative affect [101]. Moreover, when faced with trauma-related affects, memories, or cognitions, survivors might experience overwhelming distress and be constrained to use avoidance as a way to deal with these negative affects. Despite its alleviating effect on the negative emotions associated with trauma-related intrusive and distressing memories, avoidance may also disrupt psychological well-being and further development of regulation skills, both of which are essential to adult functioning [10, 63]. Thus, empirical data have provided support for these theoretical propositions by showing that adult survivors of childhood interpersonal trauma tend to exhibit affect dysregulation as reflected by emotional instability, a tendency to overreact to negative or stressful events, problems in inhibiting the expression of strong affects, and the use of tension reduction behaviors [10, 64, 102–104].

3.1.6. *Substance use disorders*

Substance use disorders are relatively common among individuals who were exposed to traumatic events, especially those who have experienced interpersonal trauma [64, 105, 106]. Results from the Adverse Childhood Experiences (ACE) study showed a strong graded association between the risk of drug initiation from early adolescence into adulthood and problems with drug use, drug addiction, and parenteral use. Results also showed that,

compared to individuals with no ACEs or no experience of childhood interpersonal trauma, those with more than five ACEs were 7–10 times more likely to report illicit drug use problems, addiction to illicit drugs, and parenteral drug use [107].

Resorting to alcohol and drugs could be well understood along the lines of Briere's Self-Trauma Model under the spectrum of insufficiently developed affect regulation [108]. In contrast to the positive and caring environment within which a child generally develops, chronically abused or neglected children may have been exposed to insurmountable affective obstacles, such as emotionally intolerable physical or sexual abuse, or persistent, invasive psychological abuse. Without a basic safe environment for the development of optimal skills, victims may become experts at using more powerful avoidance strategies such as substance abuse, allowing them to "function" despite their otherwise overwhelming distress [12, 109]. Based on clinical experience with substance-using survivors, Briere and Scott [24] also suggest that insufficiently processed trauma-related distress may motivate the use of drugs and alcohol in an attempt to "self-medicate." Thus, drugs and alcohol use would contribute to decreased environmental awareness and at the same time, involvement in risky behaviors. Unfortunately, those circumstances increase the likelihood of erratic behaviors and additional trauma, and associated posttraumatic stress, ultimately leading to greater distress and substance abuse [10].

3.1.7. Eating disorders

Mixed findings are observed regarding eating disorders in childhood interpersonal trauma survivors. Documented in children and adolescent survivors, eating disorders are also known to persist in adulthood [110]. A recent study using a representative sample of men and women across the United States [111] found that the vast majority of women and men with anorexia nervosa, bulimia nervosa, and binge eating disorder reported a history of childhood interpersonal trauma. Even though sexual abuse is more often identified as a potential risk factor for eating psychopathology, recent findings demonstrate the role of different types of childhood interpersonal trauma (i.e., childhood psychological and physical abuse, childhood psychological and physical neglect) in the etiology of eating psychopathology [112].

According to some researchers, childhood interpersonal trauma might contribute to poor self-esteem or even self-hatred, which might result in binge eating as a way to punish one's own body or to use dissociative coping strategies. Childhood interpersonal trauma might also make the survivors feel as if their life is out of control, contributing to a need to re-exert control through self-starvation (see [113]). Other theoretical avenues suggest that the link between childhood interpersonal trauma and eating disorders may lie on emotion regulation difficulties arising from poor parental models of distress regulation and tolerance, which result in a limited repertoire of emotion regulation strategies in the lifespan [114]. For instance, impulsivity and compulsivity in childhood interpersonal trauma survivors might manifest as disordered eating behavior, such as binge eating and compensatory behaviors (e.g., purging, laxative use), used to cope with trauma [115].

3.1.8. Suicidal behaviors

Among the wide range of repercussions observed in the aftermath of childhood interpersonal trauma, one of the most troubling is the development of suicidal thoughts and behaviors [116]. Several studies suggest that psychological, physical, and sexual abuse is related to later suicidal ideation, threats or attempts [117, 118]. More precisely, survivors of childhood interpersonal trauma are 2–5 times more likely to manifest suicidal thoughts or behaviors when compared to non-victims [119, 120]. Although no definite consensus prevails pertaining to the type of childhood interpersonal trauma that is most associated with suicidality, numerous theories have been proposed to explain this relationship.

Suicide-focused theories support the potential role of childhood interpersonal trauma as an etiological factor for suicidal behaviors. Based on the Suicidal Mode Theory [121] and the Interpersonal-Psychological Theory of Suicide [122, 123], childhood interpersonal trauma may lead to feelings of social alienation and produce emotions and cognitions (e.g., involving helplessness and hopelessness) that leave survivors with a persisting vulnerability for suicidal ideation and behaviors. Other authors have also hypothesized that suicidality might result from a desperate search to avoid or reduce abuse-related affective states and posttraumatic stress [10, 124].

3.1.9. Alterations in attention and consciousness

Alterations in attention and consciousness can take multiple forms including dissociation, depersonalization, memory disturbances, concentration difficulties, and disrupted executive functioning [1, 125]. Dissociation is a common response to traumatic events, including childhood interpersonal trauma [24, 126, 127]. According to the *DSM-5*, dissociation is “a disruption of and/or discontinuity in the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control and behaviour” (p. 291). Dissociation is often viewed by clinicians and researchers as an avoidance strategy used to temporarily numb, distract, or forestall negative experiences, thereby redirecting attention away from otherwise overwhelming emotions [10]. Several studies have documented the role of childhood physical abuse as a predictor of dissociation; yet, Haferkamp et al. [38] showed that emotional components of trauma such as psychological abuse were also correlated with dissociative symptoms in adulthood. Moreover, the experience of different types of childhood trauma (e.g., cumulative trauma) is increasingly documented as being associated with dissociation. For example, the total number of different types of interpersonal trauma is associated with dysfunctional avoidance and symptom complexity in adults, including dissociation [10, 76].

Liotti’s model [128] suggests that the primary function and etiology of dissociation is as a defense against trauma. While the tendency to use avoidance to cope with negative emotional states caused by memories of the abuse may, at first, provide relief from trauma-related stress, avoidance has been identified as an important risk factor for subsequent psychological problems in trauma survivors [129]. Over the long haul, avoidance can generate negative outcomes because it reinforces fear beliefs [130], prevents the survivor from the

opportunity to create new structures of associations [131] and paradoxically, tends to exacerbate initial distress (see the Pain Paradox [24]). The use of dissociation in trauma survivors would also be maintained by a conditioned behavioral response (e.g., negative reinforcement) within which suffering and distress are temporary alleviated. As such, the effectiveness with which avoidance strategies quickly relieve survivors' distress keeps them in a behavioral loop [132].

Also observed in interpersonal trauma survivors is "other-directedness" attention [12]. Early abuse typically pulls the child's attention away from internal experiences toward the environment because that is where potential danger exists and it must be gauged. This ongoing "other-directed" attention prevents the child from developing a coherent sense of self and impedes optimal psychological functioning in adulthood since it precludes from internal self-monitoring and self-awareness [102]. Attentional difficulties in the aftermath of a traumatic event such as childhood interpersonal trauma are well documented, with general consensus that these attentional disturbances are due to posttraumatic stress [133, 134].

3.1.10. Attributions

Attribution theory states that individuals have a vital need and tendency to explain the cause of events, especially when they are unexpected, unwanted or unusual, such as traumatic events [135]. To explain trauma, an individual may thus attribute its cause to either external or internal factors [136].

When traumatic events are attributed to external factors, individuals may believe that the traumatic experience and its related effects result of chance or the actions of others rather than by their own actions. In contrast, those who attribute such events to internal factors believe they are responsible for the trauma and its repercussions [136]. Attributional styles are associated with how one will respond to an event, either by alleviating or exacerbating the psychological sequelae and distress associated with trauma [136, 137]. For instance, children who have sustained interpersonal trauma often exhibit distorted attributions about themselves and the world that might set the stage for generalized shame and guilt, poor self-efficacy, and external locus of control [138, 1]. Self-blame, shame, and guilt are common sequelae of childhood interpersonal trauma and may lead survivors to hold themselves accountable for the victimization and even think they « asked for it » or « deserved it » [139, 140]. In addition, since early interpersonal trauma experiences are likely to occur within the caregiving system, the child may be cautioned or threatened to conceal the abuse, creating even more guilt, greater sense of betrayal, and a continual state of anxiety and hypervigilance [141].

In the long run, internal attributions of blame for childhood interpersonal trauma are generally associated with greater psychological distress and more depressive, anxious, and intrusive symptomatology [136, 137]. In addition, childhood interpersonal trauma survivors are prone to low self-esteem, and overestimation of danger, more commonly when they have experienced chronic trauma, as a result of which they develop a sense of having little power to affect future potentially negative events [24]. Taken together, these cognitive repercussions might generate pervasive predicaments in understanding others' behaviors

and taking responsibility for one's own behavior and experiences in childhood trauma survivors [1].

3.2. Interpersonal repercussions of childhood interpersonal trauma

The peculiarity of childhood interpersonal trauma lies in its relational context. Indeed, interpersonal trauma includes elements of malevolence, betrayal, and disregard, which lead to feelings of insecurity about the trustworthiness of others [142, 143]. As such, when faced with an abusive caregiver, a child tends to develop disruptive styles of coping and relating to others and to oneself [12, 144] as well as enduring cognitive models about the self, others, the world, and the future known to generate hardships in subsequent interpersonal relationships [24, 145]. Survivors would thus experience interpersonal traumatic events as more "traumatizing" than non-interpersonal trauma (such as natural disasters) [53, 109, 146]. Hence, compared to impersonal traumatic stressors, such as natural disasters or motor vehicle accidents, interpersonal trauma during childhood is presumed to cause more detrimental and severe outcomes due to its deliberate nature [13, 147].

Several theoretical perspectives (e.g., social learning, object relations, attachment) suggest that individuals build expectations about others and relationships based on their interactions with significant others, especially in childhood [148–150]. In the context of early interpersonal trauma, survivors may develop negative schemas, beliefs, cognitions, and behaviors that impact the formation and maintenance of positive interpersonal relationships across the lifespan [151, 152]. Consistent with this assumption, recent studies have highlighted that childhood interpersonal trauma impairs the development and maintenance of adaptive relationships in childhood and beyond [35, 153]. For instance, early interpersonal trauma has been associated with poor social functioning and conflict resolution skills, problematic adult relationships and sexual adjustment [145, 151, 154], as well as beliefs that others are not trustworthy or will not provide adequate support when called upon [145]. In response to these convictions, survivors tend to exhibit lower social support [155], higher social isolation [156], domineering and controlling behavior [145], as well as distance in interpersonal relationships [157].

Romantic relationships generally represent the most important, yet challenging, interactions for a majority of adults, especially for survivors of childhood interpersonal trauma. As such, commitment to a romantic partner can be difficult [151] and survivors' disruptions in the formation and maintenance of interpersonal relationships would be especially salient in romantic relationships [158]. The development of commitment and intimacy may increase feelings of vulnerability and trigger unresolved issues, emotions, and cognitions associated with past traumatic experiences [159]. A review of the theoretical, clinical, and empirical literature also suggests that, once these relationships are formed, childhood interpersonal trauma survivors are more likely than non-survivors to report dissatisfaction, separation, or divorce [151]. Thus, even when survivors are able to commit to a romantic partner, their relationships are generally more dysfunctional, exhibit lack in closeness, feelings of affection, and personal disclosure [160] and show greater couple and sexual dissatisfaction [17, 154].

Studies are generally consistent with life course perspectives, whereby some of the repercussions associated with childhood interpersonal trauma are exacerbated by the relational nature of the couple relationship [13, 161]. The following sections provide an overview of some of the most documented relational posttraumatic repercussions of early interpersonal trauma: dysfunctional attachment patterns, sexuality and violence in intimate relationships.

3.2.1. Attachment

Several skills that are required for optimal relational functioning in adulthood are developed during infancy and childhood within caring and responsive bonds with primary caregivers [12, 149, 162, 163]. According to Bowlby's attachment theory [149, 162, 163], children are motivated to seek proximity to a caregiver or an attachment figure when faced with emotional distress or threats. When caregivers are able to provide comfort and reassurance, it allows the child to pursue nonattachment goals in a safe environment with the belief that they will be available if needed [164]. On the contrary, violent or abusive parents reduce the caregiver's capacity to attend to a child's needs and may challenge the child's confidence in the parents' availability and responsiveness [12, 165]. Children who are exposed to parental violence are less likely to have their basic need for available and consistently responsive caregivers fulfilled, thus preventing the development of a core sense of security in relationships [166]. Consequently, an abusive or neglectful relational context with a primary caregiver, in which a child experiences harm, or is neglected by an attachment figure, is likely to produce long-lasting relational difficulties through attachment insecurities [17, 165], particularly since children exposed to interpersonal trauma must deal with their attachment figures as potential sources of danger [167]. Indeed, attachment insecurities are overrepresented in adults who have been neglected, physically abused, or sexually abused during their childhood [168–170].

In adulthood, since the romantic partner often becomes the person toward which a distressed individual turns to for comfort and reassurance [171, 172], researchers have suggested that early attachment bonds share similar attachment features with the romantic partner's relationship [173, 174]. According to Brassard and Lussier [175], attachment insecurities in romantic relationships are shaped along two dimensions: abandonment anxiety and avoidance of intimacy. Abandonment anxiety refers to the extent to which one holds a negative or positive model of oneself and a perception of being worthy and loved. Interpersonal trauma survivors generally present a hyperactivation of this attachment system represented by intense demands of affection, a sensitivity to perceived or real threats of rejection by the partner, a certain control over the partner's behaviors, or an excessive dependence toward the partner in reaction to the perception that the other is insufficiently available to answer one's own needs of love and protection. Avoidance of intimacy depicts individuals who are uncomfortable in intimate contexts especially within close relationships and who see others as being untrustworthy or unavailable [164].

According to Godbout et al. [176], childhood interpersonal trauma hinder one's opportunities to develop the interpersonal skills that are essential to satisfactory intimate relationships such as the ability to trust others and understand the mental states that underlie their

behaviors. In essence, the violent dynamics in which a survivor's first interpersonal encounters take place might shape dysfunctional interaction patterns that will be repeated in subsequent relationships. For example, abusive or neglectful experiences can produce fear of intimacy, which, in conjunction with the need for connection, leads to ambivalent, chaotic, or transient intimate relationships [176]. Hence, when lack of mutuality prevails in couple interactions, a survivor's perceived vulnerability might trigger power responses, used to protect oneself, further diminishing the already compromised relational processes of the couple [177].

In certain cases, parents who are not able to provide a safe haven for their children offer them frightening or unpredictable caregiving. As a result, children fail to organize a coherent strategy for ensuring protective access to their caregiver and tend to develop insecure representation of themselves, others, and the world [178]. Recent studies have referred to these difficulties as disorganized attachment [179–181]. Arising from the inability to deal with distress in the caregiver's presence [182, 183], disorganized attachment depicts a set of both approach and avoidance strategies [167] that persist across the lifespan [184]. In adulthood, survivors with a disorganized attachment style are known to have the most acrimonious romantic relationships [185].

3.2.2. *Sexuality*

A growing body of research shows that childhood interpersonal trauma, especially child sexual abuse (CSA), is associated with the presence of sexual difficulties in adulthood (e.g., [161, 186, 187]). Childhood interpersonal trauma often involves a malicious intent from the abuser, or betrayal from an attachment figure [143]. This betrayal feeling is likely to be reactivated in the context of adult close relationships and to generate difficulties in the sexual sphere. Sexual intimacy is a context in which the individual is vulnerable and where relational issues are likely to be re-evoked. This is especially difficult and anxiety-provoking for childhood interpersonal trauma survivors with trust issues, breakage boundaries, feelings of helplessness and betrayal.

According to Finkelhor and Browne's [188] traumagenic dynamics model, the impact of childhood interpersonal trauma on sexuality can be understood through four dynamics: *betrayal, traumatic sexualization, stigmatization, and powerlessness*, which are believed to "alter children's cognitive and emotional orientation to the world, and create trauma by distorting children's self-concept, world view, and affective capacities" (p. 531). Scientific literature highlights two trajectories within which sexual outcomes of CSA can be classified: sexual avoidance and sexual compulsivity [189, 190]. Sexual aversion, negative sexual attitudes, a wide range of sexual dysfunctions including vulvodynia, lack of interest in sex, orgasmic difficulties (see [191–194]), and lower sexual self-esteem [195] are examples of avoidance-related outcomes of CSA. In contrast, sexual compulsivity manifests as excessive sexual concerns, initiation to sex at an early age, an elevated number of sexual partners, risky sexual behaviors, and extradyadic sexual involvement [159, 196–198].

Regardless of the related trajectory, avoidant and compulsive sexual behaviors are conceptualized as dysfunctional coping mechanisms used to soothe, reduce, or distance from suffering traumatic memories, or to reinforce self-esteem as it was shattered by the experience of childhood interpersonal trauma [199, 200]. Yet, clinical and empirical observations reveal that those sexual outcomes are not necessarily exclusive and that mixed behaviors of avoidance and compulsivity are often present, underlying some sort of sexual ambivalence [190]. Multiple experiences of childhood interpersonal trauma are also found to predict lower levels of sexual satisfaction [29, 201]. Indeed, sexual repercussions of childhood interpersonal trauma not only pertain to CSA: increased risk of sexually transmitted diseases and risky sexual behaviors (i.e., sex with uncommitted partners, unprotected sex, impulsive sex, or risky anal sex) have also been observed in survivors of neglect, psychological and physical abuse [39, 202, 203]. Although research in this direction is still at an early stage, recent results suggest that childhood interpersonal trauma hinders sexual fulfillment and pleasure and the perception of living a satisfying sexuality [161, 204, 205].

3.2.3. Violence in intimate relationships

A large body of literature has reported an association between childhood interpersonal trauma and an increased risk of sustaining [52, 206] and of perpetrating [165, 207] intimate partner violence (IPV) in adulthood. Indeed, most victims of IPV [208], the majority of convicted batterers [209] and individuals from clinical samples who report having experienced IPV [69, 210] disclose high rates of childhood interpersonal trauma, ranging from 30 to 80% [209]. In the scientific literature, this phenomenon is referred to as the intergenerational transmission of IPV [211, 212]. According to those studies, growing up in a violent home would increase the probability of experiencing IPV in adulthood by 2–4 times [213]. However, not all victims of childhood interpersonal trauma become IPV perpetrators nor are revictimized [212, 214].

One of the most prominent theoretical explanations for the intergenerational transmission of IPV has its roots in the social learning theory [215], which posits that through behavioral conditioning, modeling, and observational learning, children raised with violence will come to consider violence as an appropriate response to conflict [211]. Indeed, by seeing the use of violence being reinforced (the resulting control of the partner or of the situation) or normalized, survivors of childhood interpersonal trauma would learn to use violent rather than nonviolent methods to resolve disputes or conflicts, thus integrating positive attitudes toward violence [216, 217]. Still, social learning theory does not sufficiently describe the association between early interpersonal trauma and IPV since it does not explain why some survivors of childhood interpersonal trauma experience later IPV while others do not. In addition, in a recent meta-analysis, Smith-Marek et al. [211] found a weak-to-moderate association between childhood interpersonal trauma and later IPV, with an overall effect size of 0.25 for perpetration and 0.21 for victimization across 124 studies. The high proportion of unexplained variance suggests that other possible factors might interact with the experience of early interpersonal trauma over the course of a survivor's life and contribute to later IPV.

In response to these shortcomings, researchers have suggested that children who grow up with violence, through social learning mechanisms and the influence of temperament or personality factors, may be more prone to develop an aggressive interpersonal style that is related to violence in intimate relationships [218, 219]. According to the bioecological perspective [220], individuals biologically inherit traits and tendencies that are strengthened or weakened by their relational experiences. This suggests that although early victimization continues to have an impact on adult functioning, this influence will be partly explained by other relational risk and protective factors that interact with the experience of early interpersonal trauma [216]. Consequently, a number of researchers have examined situational factors, usually pertaining to communication or conflicts that set the stage for violent interactions between romantic partners [216, 221, 222]. By combining these theoretical perspectives, IPV can thus be considered as a dynamic process that emerges as a result of early and situational relational experiences, learning processes, and biological affective dispositions [216]. Nevertheless, the fact that the strength of the relationship between early interpersonal trauma and adult IPV varies across studies calls for further studies exploring the mechanisms that might explain why some survivors of childhood interpersonal trauma experience IPV during adulthood while others do not [97]. For instance, Arata et al. [223] have suggested that the experience of multiple types of childhood interpersonal trauma, known to generate more important and complex repercussions than a single type of interpersonal trauma, could partly explain these different trajectories.

4. Conclusion

This chapter aimed to provide an overview of the long-term repercussions of childhood interpersonal trauma that persist in adulthood. This literature review demonstrates the extent to which childhood interpersonal trauma impacts multiple spheres of adult functioning, ranging from classic posttraumatic stress to violence in intimate relationships or sexual dissatisfaction. These outcomes, often considered as direct consequences of early interpersonal trauma, might also be causal mechanisms that trigger or exacerbate the onset of a series of psychological and relational difficulties in adulthood.

As such, trauma-related symptoms often extend beyond posttraumatic stress in an array of complex symptoms including depression, self-destructive behaviors, dissociation, substance abuse, somatic symptoms, and high comorbidity with other psychological disorders [31, 51, 53, 68]. For instance, affect regulation difficulties and posttraumatic stress following childhood interpersonal trauma might enhance the risk of experiencing IPV in adult survivors [52, 100, 210]. Interferences in the sense of attachment security may also preclude maintenance or reestablishment of emotional equanimity during and following trauma, thereby contributing to the formation of posttraumatic stress symptoms [166]. In contrast, if internal or external sources of support can be mobilized during or after a traumatic event, attachment security could act, at least to some extent, as a protective shield against the development of emotional problems following trauma, including posttraumatic stress symptoms [166]. Another example of the intermediate role of childhood interpersonal trauma repercussions to explain posttrau-

matic stress is the presence of peritraumatic dissociation that occurs during or immediately after a traumatic experience that appears to be strongly and consistently related to the presence of posttraumatic stress symptoms in adulthood [224].

However, following decades of research and prevention campaigns and despite dreadful consequences and economic effects (15M per year in judicial, health, education, employment, and personal costs in Canada [225]), early interpersonal trauma remains an understudied phenomenon, especially with regard to the identification of protective factors, such as partner support or certain personality traits, that might temper its effects on psychological and relational adult functioning. In addition, early relationships are a crucial part of the psychosocial scaffolding on which adult psycho-relational health rests yet, since personal history, relational experiences, and psychological adjustment are interrelated, future studies must consider multiple variables [13]. The challenges associated with the development of such studies lie in the plethora of intrapersonal, environmental, and interpersonal variables that must be examined but are better studied using longitudinal and systemic research protocols. As such, future studies should aim at following childhood interpersonal trauma survivors throughout as many years as possible, while assessing specific variables in the survivor's close relationships (e.g., parental, social and partner support). Integrative models, including both psychological and relational variables should also be examined in order to better understand the survivor's psychological and social development following childhood interpersonal trauma.

Also, given the substantial proportion of individuals who report any experience of childhood interpersonal trauma, health professionals are likely to encounter patients with trauma history. In this regard, they must acknowledge how these early experiences can shape both psychological and interpersonal functioning in order to properly evaluate and provide a treatment that is well-suited to survivors' needs and capacities. By recognizing the lasting and pernicious effects of childhood interpersonal trauma, therapists will be more able to validate the survivor's traumatic experience. Moreover, with the assistance of a secure and sincere therapeutic alliance, therapists who work with trauma survivors should be able to provide a warm, safe, and empathic environment that will help survivors in cultivating a new conception of interpersonal relationships. Thus, by providing a space to create new representations of the self and of others, therapists will grant survivors with a sense of hope and a feeling that their traumatic experience or actual symptoms do not define who they are.

Being aware that childhood interpersonal trauma survivors may lack self-regulatory or relational skills might also give therapists a sense of the importance of gradual exposure that will allow the survivor to develop new abilities and experiences [24]. In cases where a survivor's romantic relationship is characterized by emotional depth, relationship satisfaction, and adjustment, this particular relationship can also participate in a powerful healing experience. Indeed, healthy romantic relationships can foster a survivor's adjustment by facilitating a reorganization of dysfunctional schemes and cognitive processes that were developed in the context of childhood interpersonal trauma. In the same way as a sincere therapeutic alliance, romantic relationships can provide a space to explore new healthy relationship dynamics that

will foster the survivor's psychosocial adjustment through the promotion of positive representations of self, others, and the outside world [176].

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