Childhood experiences of violence in perpetrators as a risk factor of intimate partner violence: a systematic review

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ABSTRACT

Background Perpetrators’ experiences of violence during childhood are considered a risk factor for intimate partner violence (IPV). The objective of this study is to systematically review the characteristics and quality of papers which analyse the association between being battered during childhood, witnessing marital violence as a child within the family of origin and having an absent or rejecting father and the occurrence of IPV.

Methods Nine scientific databases were consulted (1960–2004). After applying the exclusion criteria, 10 studies were analysed. Variables are sample characteristics, directionality/study design, IPV and perpetrators’ childhood measurements, findings, limitations and interventions.

Results All the studies found an association. Conflict Tactics Scale was the main tool used to measure the IPV. Different instruments were used to measure violent childhood experiences in men as an exposure. Recall bias (seven papers) and retrospective data (four papers) were reported as the main methodological limitations. Despite these, 50% of the studies proposed treatments/preventive measures.

Conclusion Our findings support the results of previous studies, implying that action recommendations within IPV prevention are still not evidence based. Methodological problems of the papers reviewed should be solved to obtain more useful data. Scientific evidence about the aetiology of IPV should be increased to guide effective prevention programmes.

Introduction

The increasing relevance of intimate partner violence (IPV) in the scientific and political agenda as a public health issue1–4 has given different explanations of its aetiology. Lori Heise’s5 ecological framework for violence against women is the most cited one in the literature. This model explains that a suitable approach to the phenomena should focus on the complexity of different levels: individual, family/relationship, community and societal. Several studies about each of the IPV risk factors identified in Heise’s model have been recently published; such is the case of those papers addressing the role of perpetrators’ alcohol consumption6 and socioeconomic status7 as risk factors for IPV.

According to Heise’s model, being exposed to violence during childhood is considered a risk factor for IPV at the individual level. This determinant distinguishes three situations: being battered during childhood, witnessing marital violence as a child within the family of origin and having an absent or rejecting father. Two empirical reviews prior to 1990s8,9 on this topic conclude that for violent adult males, the most consistent risk factor for perpetrating husband-to-wife violence was having witnessed violence as a child in the family of origin.

However, a theoretical review carried out 10 years ago by Feldman10 on violence against women calls for caution in drawing causal conclusions based on these particular studies on a perpetrator’s childhood as a risk factor. The author reports the conclusions of different papers focused on the aetiology of violence against women, and states that the authors of the reviewed articles recognised two important limitations in their studies: the weaknesses inherent in the use of retrospective study designs with adults and recall and social desirability biases.

The rising prevalence of IPV has promoted the creation of prevention and treatment programmes targeted at the
rehabilitation of the aggressors. Given that the last review of this issue offers a theoretical perspective, we propose a public health evidence-based approach to prove the influence of violent childhood experiences on perpetrators. This could provide valuable information for both policy-makers and health professionals involved in the prevention of this problem. Consequently, we have systematically reviewed the characteristics and quality of the published papers which specifically analyse the association between being battered during childhood, witnessing marital violence as a child within the family of origin, having an absent or rejecting father during childhood (exposure) and the occurrence of IPV (outcome).

**Methods**

The fields of Social and Behavioural Sciences, Clinical Medicine and Life Sciences were searched using the following databases in all the available years: Medline (1966–2004), Science Citation Index (1945–2004), Social Science Citation Index (1956–2004), Current Contents (1998–2004), PsycINFO (1887–2004), Sociological Abstracts (1963–2004), ERIC Database (1966–2004) and Social Service Abstracts (1960–2004). To identify the keywords, the thesaurus (MESH) was used in all the available databases, except in the Science Citation Index and Current Contents.

The inclusion criteria for this review were: (i) empirical studies, (ii) quantitative methodological studies, (iii) analysis of the variable risk factors ‘being a man battered during childhood, witnessing marital violence within the family of origin or having an absent or rejecting father’ (exposure markers) and its effect on the occurrence of ‘IPV against women’ (outcome).

The main exclusion criteria in this review were defined and justified due to the high prevalence of this problem in men as perpetrators and women as victims of IPV. Also, a scientific approach based on male perpetrators may help for the analysis of the political, social and psychological mechanisms that legitimize the social position of men and women and their impact on social problems such as IPV. All those papers covering the following two main topics were excluded: (i) women victims of violence during childhood and the impact of this on their becoming violent towards their partners in adulthood and (ii) women and men who suffer violence during childhood and how this increases their chances of becoming victims of violence in adulthood (revictimization).

Furthermore, papers on the following issues were also excluded from the review process: treatments and programmes against IPV, other violence-related issues (e.g. alcohol and drug consumption in perpetrators), aggressors’ mental illness and its impact on IPV, consequences of childhood violence on children’s health and qualitative articles and reviews.

The search equations used were:

(i) Battered women and battered children—battered child syndrome’.
(ii) Battered females and battered child syndrome.
(iii) Violence against women and men childhood, childhood factors’.
(iv) Domestic violence and childhood.
(v) Family violence and childhood experiences, childhood violence, battered children, battered child syndrome, battered children.
(vi) Partner abuse and battered child syndrome.
(vii) Spouse abuse and battered child syndrome, childhood experiences, childhood experiences, childhood factors.
(viii) IPV and men childhood and violence.

The titles, abstract and full text of each paper were examined, omitting those studies determined by the exclusion criteria. A content analysis of the papers included was performed and codified independently by two authors (D.G.-G. and C.V.-C.), using an ad hoc developed checklist that included the studies’ methodological characteristics, their findings and the self-acknowledged limitations.

(i) Year of publication.
(ii) Characteristics of the studied population: sample, sex and age.
(iii) Classification of the type of analytical study design used: cross-sectional, case-control and cohort.
(iv) Directionality: retrospective/cross-sectional/prospective.
(v) Inclusion of Heise’s model variables (non-excluding variables):
   (a) Being battered during childhood (yes/no).
   (b) Having witnessed marital violence as a child within the family of origin (yes/no).
   (c) Having an absent or rejecting father during childhood (yes/no).
(vi) Scale or instrument to measure outcome (IPV).
(vii) Scale or instrument to measure exposure (violent childhood experience in men).
(viii) Other variables taken from Heise’s model at the family/relationship, community and societal levels (yes/no).
(ix) Limitations mentioned in the papers.
(x) Main findings.
(xi) Conclusions about the acknowledged limitations.
(xii) Types of suggested measures: preventive and/or treatment interventions.
A simple concordance study was implemented in order to estimate the level of disagreement among the researchers who reviewed the papers. The codifiers and classifiers (D.G.-G. and C.V.-C.) independently analysed a sample of 10 papers. A high level of concordance (90%) was obtained.

A formal meta-analysis was not conducted for two reasons: first, due to the heterogeneity of the studies as regards design, study populations and exposure and outcome measurements, and secondly given the lack of studies including odds ratios or similar effect sizes which could be weighted into a combined estimate. A descriptive study (frequencies and percentages) of the variables included in the review was performed using SPSS 11.5 and Excel-2000 commercial software.

**Results**

Three hundred and fourteen papers were identified from all the years available in the reviewed bibliographic databases. After applying the exclusion criteria, 10 papers were selected. The 304 excluded papers were related to the following issues: women victims of violence during childhood and the impact of this on their becoming violent towards their partners in adulthood (n = 40; 13%), women and men who suffer violence during childhood and how this increases their chances of becoming victims of violence in adulthood (revictimization) (n = 20; 7%), treatments and programmes against violence (n = 19; 6%), other violence-related issues (e.g., alcohol and drug consumption in perpetrators), aggressors’ mental illness (n = 136; 44%), consequences of childhood violence on children’s health (n = 78; 26%), and qualitative papers and reviews (n = 11; 4%).

The papers that fulfilled the inclusion criteria were published between 1995 and 2004. The relations between the experience of being battered during childhood and IPV was explored in eight studies, Six of these studies and their main findings. The studied populations are prospective data are used in all the studies, whereas four other studies compile information only from male population samples. In addition, the age range of these populations varies significantly.

Only variables related to the individual were taken into account as possible confounding or interaction factors in the analysis model: impulsivity and depression, negative emotionality, harsh discipline from grandparents, antisocial behaviour, stress and alcoholism. The Conflict Tactics Scale was the main methodological tool used by the studies to measure IPV as an outcome. However, different instruments were used to measure violent childhood experiences in men as an exposure factor and did not take into account the same risk factors. They included variables about diverse violent acts related to different contexts within men’s lives (personal experiences, family issues, and social environment). This is the case of the Child Trauma Questionnaire, a brief version of the severe variables related to child abuse adapted from the Conflict Tactics Scale or the Antisocial Behaviour Trait Scale. Other family/relationship, community and societal risk factor variables from Heise’s model were not taken into account in the reviewed papers.

Table 2 shows the main limitations highlighted by the studies’ authors, most of them related to the information (recall) bias and linked to the usage of retrospective data. The generalization of the findings to the whole population (external validity) is a problem identified by 50% of the studies as only men were interviewed; most of these samples are not based on the general population and they are, therefore, heterogeneous. The small size of the samples is also a recognized limitation mentioned in two studies. The use of the Conflict Tactics Scale is questioned as it oversimplifies the patterns of violence by emphasizing physical assaults on a partner without taking into account the social context of the affected population and other kinds of IPV risk factors.

The authors conclude their papers by proposing treatments focused on different prevention levels. Three studies recommend screening followed by treatment targeted at men, especially for those with a high risk of perpetrating violence. Some authors suggest that primary health care prevention measures should be applied to reduce the incidence of physical abuse while behavioural family therapy treatments should be implemented to decrease the IPV risk factors. As regards further studies, 70% of the papers state that new lines of research are required to deal with this problem, including an analysis of women’s perceptions of violence. Meanwhile, new studies using prospective data are also considered to be necessary as well as studies to measure the association between IPV and...
Table 1 Methodological characteristics and findings of the studies about the intergenerational learning of IPV (1995–2004)

<table>
<thead>
<tr>
<th>Year of publication: first author</th>
<th>Main characteristics of the population</th>
<th>Study design (directionality)</th>
<th>Exposure: measurement of violent childhood experience</th>
<th>Outcome: measurement of intimate partner violence</th>
<th>Findings: Associations between violence childhood experience and intimate partner violence</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004: Schafer21</td>
<td>1427 couples Mean age: 42.3, women; 44.8, men 48 States</td>
<td>Cross-sectional: retrospective data</td>
<td>Brief version of severe variables related to child abuse adapted from Conflict Tactics Scale.</td>
<td>Conflict Tactics Scale: Verbal aggression and physical violence.</td>
<td>History of being physically harmed by parental figures during childhood, impulsivity and drinking problems are all risk factors for IPV in couples from United States.</td>
</tr>
<tr>
<td>2003: Orcutt18</td>
<td>376 Vietnam veterans and their partners. Age not reported</td>
<td>Cross-sectional: retrospective data</td>
<td>Family dysfunction. Relationship with mother/father. Perceived threat. Childhood antisocial behaviour. Post-traumatic stress disorder.</td>
<td>Conflict Tactics Scale: Partners’ reports of recent male-perpetrated IPV among couples.</td>
<td>Poor relationship with mother was related to IPV (P &lt; 0.01). Poor relationship with father was not associated with IPV.</td>
</tr>
<tr>
<td>2003: Whitfield19</td>
<td>8629 (women, 4674; men, 3955) Mean age: 55, women; 57, men. Adverse Childhood Experiences Study</td>
<td>Cross-sectional: retrospective data</td>
<td></td>
<td>Conflict Tactics Scale: Verbal aggression and physical violence.</td>
<td>Violent childhood experience was associated with IPV: 3.8 (1.8–8.1)</td>
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<table>
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<tr>
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</tr>
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<tbody>
<tr>
<td>2002: Carr17</td>
<td>99 Undergraduate men. Average age, 20 years. Midwestern University</td>
<td>Cross-sectional: retrospective data</td>
<td>Sexual experience survey (male version).</td>
<td>Conflict Tactics Scale: Physical/sexual violence. Following sub-scales: Hostility towards women, Adversarial sexual beliefs, Acceptance of interpersonal violence, and Rape myth acceptance.</td>
<td>Witnessing IPV as a child predicted the perpetration of physical violence in college men ($P &lt; 0.01$)</td>
</tr>
<tr>
<td>1998: Oriel13</td>
<td>375 men. Age, 18–60 years. Family Medical Clinics</td>
<td>Cross-sectional: retrospective data</td>
<td>Conflict Tactics Scale.</td>
<td>Conflict Tactics Scale: Verbal aggression and physical violence.</td>
<td>Presence of alcohol consumption, depression or history of child abuse resulted in a 41% probability of violence, compared with 7% if no risk factors were present.</td>
</tr>
<tr>
<td>1998: Kesner15</td>
<td>149 Couples Mean age: men, 35.78 years Midwest Metropolitan Area</td>
<td>Cross-sectional: retrospective data</td>
<td>Family of origin violence. Adult Attachment style questionnaire. Life Events Scale. Attachment history questionnaire.</td>
<td>Conflict Tactics Scale: Verbal aggression and physical violence.</td>
<td>The violent males were more likely to experience earlier parent–child attachment backgrounds in their family of origin. 1.94 (1.29–2.92)</td>
</tr>
<tr>
<td>1996: Merrill14</td>
<td>1544 (women, 882; men, 662). Mean age: women, 20.1; men, 20.2. Navy recruit trainees</td>
<td>Cross-sectional: retrospective data</td>
<td>Demographic/family history questionnaire. Child abuse potential. Conflict Tactics Scale. Michigan Alcoholism Screening Test.</td>
<td>Conflict Tactics Scale: Intimate partner physical abuse risk.</td>
<td>Childhood experience of parent–child physical violence was related to IPV (physical) ($P &lt; 0.05$) Childhood observation of parental physical spousal abuse was not related to IPV (physical) ($P &lt; 0.05$) Relationship between childhood exposures to harsh parenting/recurrent adult violence towards children/spouse was measured by the extent to which parents displayed an antisocial behaviour.</td>
</tr>
</tbody>
</table>
Table 2 Limitations mentioned in the scientific literature about the intergenerational learning of IPV (1995–2004)

<table>
<thead>
<tr>
<th>Year of publication: first author</th>
<th>Bias</th>
<th>Power and strength of the association</th>
<th>External/internal validity</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004: Herrenkhol</td>
<td>Recall bias. Lack of temporal ordering makes it impossible to know which variable precedes the other in a development sequence.</td>
<td>The small number of males, at age 24, who reported having engaged in partner violence provides low numbers at higher points on the scale. This could influence the ability of the analyses to detect predictor effects.</td>
<td>Assumption of model invariability for subsets of ethnic groups within ethnic categories. Assumption of adequate domain sampling of the variables used to represent the construct in the models.</td>
</tr>
<tr>
<td>2004: Schafte</td>
<td>Models used may be misspecified. Important variables might not be included. Changes over time weakening the basic assumptions of the model.</td>
<td>Measurement error may have weakened the ability to detect important relationships that we concluded were not significant in the current models.</td>
<td></td>
</tr>
<tr>
<td>2003: Whitfield</td>
<td>Retrospective reporting of childhood experiences, difficulty in recalling childhood events: misclassification bias. Inclusion of the term threatened with ‘pushed or shoved’ in the survey question. People may use different kinds of threats in relationships, and not all of them refer to physical violence. Brevity of the variables used in screening the complex clinical/social problems of interpersonal violence.</td>
<td>Retrospective reports of childhood abuse are likely to underestimate actual occurrence. Misclassification bias underestimates the relationships between adverse childhood experiences and the risk for IPV victimization or perpetration.</td>
<td></td>
</tr>
<tr>
<td>2002: Martin</td>
<td>Men’s reports may tend to underreport violence perpetration. Men’s ability to recall events may have varied as a function of the time period being asked about, with less recall of events which occurred in the more distant past. Missed some information of the most severe cases of wife abuse: those in which the wife actually left her abusive husband, or those in which the wife died as a result of abuse. Men were not asked about their own experiences of violent victimization.</td>
<td>Only married men who were residing with their wives at the time of the survey were interviewed. Findings may not be able to be extrapolated to men who were living apart from their wives, or to men whose wives had died.</td>
<td></td>
</tr>
<tr>
<td>2002: Carr</td>
<td>Recall bias.</td>
<td></td>
<td>Sample is not nationally representative. Findings have limited extrapolation due to the small sample assessed at just one site.</td>
</tr>
</tbody>
</table>
other risk factors. Finally, it is considered that steps must be taken to reshape the way the medical community perceives domestic violence so that a multidisciplinary perspective may be achieved.

Discussion

Main finding of this study

Our study found a consistent association between perpetrators’ childhood experiences of violence and the occurrence of IPV. The studies acknowledge problems in the quality of their own scientific research regarding this issue, due on the one hand to the use of cross-sectional designs and, on the other, to the retrospective nature of data and recall bias. There are also limitations as regards the external validity of the data. The other family/relationship, community and societal risk factor variables from Heise’s model are not considered in the studies. Although all of the studies recommend improving research on this public health problem, half of the papers put forward proposals for different types of research. Here, we present a summary of the studies included in the review.

Table 2. Continued

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<thead>
<tr>
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<th>Bias</th>
<th>Power and strength of the association</th>
<th>External/internal validity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1998: Oriel13</td>
<td>Asking men about their violent behaviour most likely resulted in underreporting of violence frequency and severity if compared with reports of those men’s partners.</td>
<td>Small samples with a constricted range of violent behaviours. Logistic odds ratios are modest in predicting male violence. Number and strength of individual predictors were limited possibly due to a limited range in the variance of the scores. Given the correlational nature of the data, causal inference can not be made.</td>
<td>Extrapolations to wider populations are limited.</td>
</tr>
<tr>
<td>1998: Kesner15</td>
<td>Self-report measures. The conflictive nature of the current relationship may have influenced the perception of antecedent factors.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1996: Merrill14</td>
<td>Self-report survey data without independent confirmation. The parenting styles of mothers are not assessed separately from fathers. Only one variable was used to examine the childhood experience of parent physical spouse abuse. Witnessing father-to-mother violence and mother-to-father violence is not assessed to determine if it had a differential impact on IPV or child abuse risk. Overlap in the recall of mother and father parental violence.</td>
<td>A substantial number of respondents failed to complete all of the questionnaires.</td>
<td></td>
</tr>
<tr>
<td>1995: Simons12</td>
<td>Recall bias. Both biological parents were present in all of the studied families, which might eliminate more highly violent families. More highly violent families with a broken marriage might be eliminated due to the abusive behaviour of one of the spouses. Thereby, these would not be represented in the sample.</td>
<td>Sampling criterion – mainly families living in small towns, likely to obtain fewer highly violent families than would be the case with a more urban sample.</td>
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</table>
of treatments focused on the early recognition of risk factors related to the IPV.

**What is already known on this topic**

The findings of this current review support the results of Feldman’s latest work (1997), implying that action recommendations within IPV prevention are still not evidence based. Thus, the screening of violent men and different therapies may be proposed based on insufficient information as regards the true role of IPV determinants. Retrospective data and information bias were, and still are, a crucial measurement problem. In fact, some of the reviewed papers highlight the need for new studies using prospective data. Moreover, as Feldman argued not only is a prospective compilation of data necessary, but also an adequate design with the inferential power to increase the quality of scientific research on this issue.

**What this study adds**

The variety of scales used to measure exposure severely affects the ability to compare the data. The analysed studies compile different information about violent experiences during childhood. Some scales gather data about being battered by the father during childhood, which implies that IPV may be a consequence of the patriarchal ideology, whereas other instruments measured witnessing father-to-mother abuse during childhood, which suggests that IPV may be a consequence of learned sexist behaviour.

The most frequent application of the Conflict Tactics Scale—as the authors of the scale argue—has been to obtain individual information on physical assaults on a partner. In addition to the criticism made about this scale by one of the studies analysed in our review, the original authors underline that this instrument does not consider social factors related to the IPV context. Furthermore, it is important to improve the tool’s capacity in order to obtain more information about IPV.

The authors consider childhood experiences of violence in perpetrators as an individual risk factor without taking into account the family/relationship, community and societal context. This could mean that IPV determinants are addressed at different levels but analysed separately, without considering all the aforementioned variables as a whole. To understand learned violence, it is important to focus not only on the individual but also on the societal context.

Scientific evidence about the aetiology of IPV should be increased to address prevention programmes. Methodological problems discussed 10 years ago by authors like Feldman and acknowledged by the authors of the papers reviewed in this article should be solved to obtain more useful data. Given the multicausal nature of this public health problem, a scientific approach based on different variables, such as the individual, family/relationships, community and society, could be of value to analyse the aetiology of the problem. Also, the role of patriarchal and sexist patterns learned in society and within the family could be taken into account in order to understand the complexity of IPV. Policies against gender violence are increasingly included in political agendas and in the mass media. Therefore, greater knowledge is required on how IPV is affected by risk factors such as childhood experiences of violence in perpetrators.

**Limitations of this study**

A limitation to this study may be that grey literature has not been included here, because policy-makers make ample use of such information when designing their prevention programmes. The fact that 90% of the studies were designed in the USA could be a potential constraint in the extrapolation of the results to the populations of other countries. Moreover, as the aim of the systematic review is to summarize the results of the papers and obtain combined conclusions, the heterogeneity of the studies could be a handicap.

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**References**