

## TRAUMA SYMPTOMS AS A BRIDGE: LINKING EARLY ADVERSITIES TO INTERPERSONAL RISK PROFILES FOR VICTIMIZATION AND PERPETRATION IN WOMEN

Federica Visco-Comandini, Carolina Papa, Luciana Ciringione, Anna Chiara Franquillo, Elena Tittarelli, Francesco Mancini, Erica Pugliese

## Abstract

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**Objective:** in the context of interpersonal violence, traumatic experiences are linked to both the risk of victimization and perpetration. Yet, most studies have examined these roles separately leaving unclear how traumatic experiences in the past and traumatic symptoms in the present may differently contribute to victimization vs perpetration-related problems. This study investigates if the relationships between early traumatic experiences and interpersonal problems typically associated with victim-like and offender-like roles are mediated by trauma symptoms (PTSD, DSO and Dissociation) in women.

**Method:** ninety-eight adult women from the general population (Mage = 33.0, SD = 8.25) completed self-report measures assessing childhood trauma exposure (CTQ-SF), trauma-related symptoms according to ICD-11 criteria (ITQ; PTSD and disturbances in self-organization), dissociative symptoms (DES-II), and interpersonal functioning (IIP-32). Interpersonal risk phenotypes were operationalized as victimization-related (friendly–submissive) and perpetration-related (hostile–dominant) interpersonal problems. An overall childhood trauma severity factor was derived from CTQ clinical subscales using exploratory factor analysis. Two parallel mediation models were tested using bias-corrected bootstrap procedures, controlling for age and marital status.

**Results:** the findings revealed that while dissociation contributes to both victimization-risk and perpetration-risk profiles, PTSD symptoms specifically foster victimization behaviors, whereas DSO symptoms are more strongly associated with perpetration behaviors. Specifically, childhood trauma was indirectly associated with victimization-related interpersonal problems through PTSD symptoms and dissociation, whereas the indirect path through DSO was not significant. Conversely, childhood trauma was indirectly associated with perpetration-related interpersonal problems through DSO symptoms and dissociation, while PTSD did not emerge as a significant mediator. In both models, direct effects of childhood trauma on interpersonal outcomes were non-significant once trauma-related symptoms were included, supporting a full mediation pattern.

**Conclusions:** in conclusion, early adverse experiences, and trauma-related symptoms, appear to make women more vulnerable to victimization/perpetration-like problems. These results clarify distinct trauma-related pathways, underscoring the need for targeted preventive interventions.

**Key words:** childhood trauma, trauma symptoms, dissociation, victimization, perpetration, interpersonal violence risk profiles, women

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## Introduction

Relational trauma refers to adverse experiences occurring within significant relationships that are perceived as threatening to one's or others lives, and that exert a lasting psychological impact (Anders et al., 2012; Baumeister & Leary, 1995). Such experiences are central to understanding the etiology and maintenance of intimate partner violence (IPV). IPV is defined as any behavior within an intimate relationship that causes physical, psychological, or sexual harm (World Health Organization, WHO, 2025). IPV includes physical assault, sexual coercion, psychological abuse, and controlling behaviors, and it is not limited to unidirectional dynamics; victimization and perpetration may co-occur within the same relationship (Langhinrichsen-Rohling et al., 2012; Stith et al., 2004).

Consistent with this framework, previous research has shown that individuals who perpetrate IPV are exposed to a higher number of traumatic events across their lifespan compared with the general population (Lamotte & Murphy, 2017; Maguire et al., 2015; Taft et al., 2016). For instance, male perpetrators have reported significantly higher rates of childhood exposure to physical and sexual abuse relative to the general population (Gilbar et al., 2019), with childhood physical abuse being approximately 4% more prevalent among perpetrators (Lev-Wiesel et al., 2018). These findings reinforce the role of early relational trauma as a key developmental risk factor in violent dynamics. This association may also be present among women who engage in abusive behaviors.

Building on this evidence, a growing body of research emphasizes the mediating role of interpersonal skill deficits in linking early traumatic experiences to later relational dysfunction (Colman & Widom, 2004), including the emergence and persistence of IPV (Papa et al., 2026; Pugliese et al., 2025). Deficits in emotional regulation, empathy, and assertive communication may represent critical mechanisms through which early trauma contributes to both victimization and perpetration within intimate relationships (Garofalo et al., 2018).

Interpersonal skills constitute a broad construct encompassing multiple dimensions such as social competence, intimacy, the ability to interpret cues from others, social desirability, and empathy (Tharp et al., 2013). Research has shown that individuals with a history of childhood sexual abuse (CSA) often experience various interpersonal difficulties, including isolation, reduced trust, and fewer relationships (Briere & Elliott, 1994). These challenges may persist into adulthood, manifesting in relationship dissatisfaction, problems with intimacy, and difficulties in sexual functioning (Davis & Petretic-Jackson, 2000; DiLillo, 2001; Pugliese et al., 2023). Such findings support the notion that early relational trauma undermines the development of interpersonal competencies, which in turn may increase vulnerability to both perpetrating and experiencing IPV (Lawson & Malnar, 2011; Papa et al., 2026; Pugliese et al., 2025).

Specifically, difficulties in interpersonal skills have been linked to sexual violence perpetration, both in incarcerated populations (Friestad & Vaskinn, 2021) and among college men (Carvalho & Sá, 2020; Loh & Gidycz, 2006). This evidence suggests that interpersonal problems resulting from CSA may serve as an explanatory mechanism for the cycle of violence.

Importantly, they represent a shared risk factor for victimization in both adolescence and adulthood, predicting self-defense ability (Anderson et al., 2020),

and one of the few violence prevention programs shown to reduce perpetration incorporates conflict resolution training (Miller et al., 2020).

## The role of traumatic symptoms in interpersonal violence risk

Chronic interpersonal trauma is associated with a spectrum of trauma-related conditions, including post-traumatic stress disorder (PTSD), complex PTSD (cPTSD), and borderline personality disorder (BPD). PTSD involves re-experiencing, hyperarousal, and avoidance (American Psychiatric Association, APA, 2013), whereas cPTSD (International Classification of Disease, ICD-11, 2019) includes core PTSD symptoms plus disturbances in self-organization (DSO: affective dysregulation, negative self-concept, and relational disturbances) linked to sustained trauma (Cloitre et al., 2018; WHO, 2025). BPD is characterized by instability of mood, self-image, and relationships, impulsivity, and intense fears of abandonment (APA, 2013). Although BPD and DSO share several features—such as affective instability and interpersonal difficulties—they represent conceptually and diagnostically distinct constructs. BPD is defined as a personality disorder characterized by pervasive patterns of instability in identity, affect, and relationships, often accompanied by impulsivity (APA, 2013). In contrast, DSO refers to a cluster of trauma-related symptoms within the ICD-11 diagnosis of complex PTSD, including affective dysregulation, negative self-concept, and relational disturbances, which are specifically linked to prolonged or repeated interpersonal trauma (Cloitre et al., 2018). While overlapping in phenomenology, DSO is conceptualized as a trauma-based adaptation rather than a personality disorder per se, reflecting different etiological pathways and clinical implications (Ford & Courtois, 2014; Karatzias et al., 2017).

Integrating the existing literature, Pugliese et al. (2024) argue that these syndromes share transdiagnostic features (e.g., emotion dysregulation) yet differentially align with IPV roles: PTSD phenomena more often characterize victimization trajectories, while DSO disturbances are more frequently observed in externalizing, control-oriented patterns relevant to perpetration (Ford & Courtois, 2014; Pugliese et al., 2024). Indeed, individuals exposed to violence commonly present PTSD symptoms—hypervigilance, emotional numbing, re-experiencing—that perpetuate re-victimization and complicate disengagement from abusive partners (Hyland et al., 2020; Iverson et al., 2013; Pugliese et al., 2023, 2025). By contrast, offenders with BPD show a greater propensity toward externalizing behavior and intense relational aggression (Caballero Guzmán et al., 2024). Specifically, affective dysregulation involves emotional lability, anger surges, and reduced impulse control, increasing the likelihood of reactive or coercive aggression during perceived attachment threat (Gilbar et al., 2019; Godbout et al., 2019). Negative self-concept is associated with shame processes and externalization of blame, which may motivate dominance-restoring or controlling behaviors toward a partner (Munro & Sellbom, 2020), while relational disturbances—including mistrust, hostility, and intimacy difficulties—foster adversarial attributions and control-seeking strategies during conflict, further increasing perpetration risk (Godbout et al., 2019; Pugliese et al., 2024).

Another transdiagnostic condition related to interpersonal trauma is dissociation (Ciringione et

al., 2025). It can represent an adaptive response to traumatic experiences that threaten an individual's psychological integrity, allowing the person to detach from the trauma in order to preserve survival. This defensive process shields the developing psyche from stressors that exceed the child's coping resources and provides immediate emotional distance from distressing experiences (Dorahy et al., 2016; Vonderlin et al., 2018). However, when traumatic experiences are chronic and relational in nature, dissociation may become progressively internalized and persistent. As proposed by Schimmenti and Caretti (2016), repeated exposure to overwhelming caregiving environments can foster a structural disconnection among emotional, cognitive, and self-representational processes. This may lead to the development of a disconnected self. In this framework, dissociation evolves from a situational defensive response into a stable mode of functioning that may persist into adulthood. It contributes to long-term difficulties in affecting regulation, identity integration, and interpersonal functioning. It may also act as a maintenance factor in the cycle of violence and contribute to interpersonal violence, in both victimizations and perpetrations (Krause-Utz et al., 2021, 2023). In victimization, dissociative symptoms can create an internal distance from abusive experiences that were uncontrollable at the time. In the long term, they may impair information processing, reduce perceived control and assertiveness. This increases vulnerability to revictimization, particularly in relationships with abusive partners (Lanius et al., 2011; Noll et al., 2003; Zamir et al., 2018).

Similarly, dissociation can contribute to a subjective disconnection from one's own abusive or violent actions during the perpetration of IPV (Webermann & Brand, 2017; Webermann & Murphy, 2019). In these cases, dissociation may manifest as a loss of control, self-observation from a distance, or episodes of blackout (Becker-Blease & Freyd, 2007; Lamotte & Murphy, 2017; Tschoeke et al., 2019). Over time, such violent acts may become compartmentalized as separate memories, disrupting integration processes and impairing adaptive problem-solving abilities (Becker-Blease & Freyd, 2007). Taken together, these dissociative processes illustrate how trauma-exposed individuals may express aggression without fully integrating intent or awareness of its consequences, blurring the boundaries between victim and offender roles.

In the present study, risk profiles for IPV victimization and perpetration are conceptualized as central analytical constructs rather than merely operational definitions. These profiles capture distinct yet potentially overlapping configurations of individual vulnerabilities (e.g., trauma-related symptoms, dissociation), interpersonal deficits (e.g., emotion regulation, empathy), and relational dynamics. By explicitly integrating risk profiles into the conceptual framework, the present study aims to move beyond an outcome-focused perspective on IPV and instead emphasize the underlying mechanisms that shape different violence trajectories. This approach helps mitigate an exclusive focus on IPV as a unitary phenomenon and supports a more nuanced, multidimensional understanding of how relational trauma, interpersonal functioning, and psychopathological features jointly contribute to both victimization and perpetration.

#### **Rationale**

Although the majority of research has focused on male perpetration of violence, a growing body of evidence indicates that women also perpetrate IPV. Female-perpetrated aggression is documented and often

multifaceted in motivation—self-defense, emotional retaliation, anger, and attempts to gain or retain a partner's attention—though distinguishing defensive from retaliatory acts is difficult (Mappin et al., 2013). Women's perpetration is frequently intertwined with their own histories of victimization, with greater victimization exposure increasing the likelihood of aggressive responding within intimate dynamics (Rizo et al., 2018). Gendered narratives in public policy and services have historically emphasized male-perpetrated IPV, rendering women's perpetration comparatively invisible and potentially limiting appropriate responses for male victims and tailored clinical care for women who offend (Carney et al., 2007; Walker et al., 2018). Women are also disproportionately exposed to interpersonal trauma (e.g., sexual violence, IPV) and often present distinct profiles—prolonged PTSD, affective dysregulation, comorbid anxiety/depression—shaped by neurobiological and psychosocial factors, including gendered norms (Olf et al., 2007; Tolin & Foa, 2006; WHO, 2025).

Within this context, understanding how trauma-related symptom patterns translate into different interpersonal outcomes becomes particularly relevant for women's mental health and safety. There is therefore a need to clarify how trauma symptoms differentially contribute to victimization- versus perpetration-related problems.

In this perspective, the present study focuses on two distinct but related risk profiles within intimate relationships: vulnerability to IPV victimization and propensity toward IPV perpetration. These profiles are conceptualized as partially overlapping yet distinguishable configurations of interpersonal functioning, reflecting different ways in which trauma-related processes shape relational behavior (Jennings et al., 2012). Specifically, victimization risk is characterized by patterns of interpersonal vulnerability, including reduced assertiveness, difficulties in boundary setting, and heightened sensitivity to threat, whereas perpetration risk is associated with control-oriented, externalizing, and coercive relational tendencies (Papa et al., 2026). Conceptualizing these profiles within the Introduction allows for a clearer understanding of how trauma-related symptoms may differentially contribute to distinct relational outcomes.

#### **The current study**

Building on evidence that trauma presentations differ across roles in intimate relationships—with distinct profiles in victimization versus perpetration (Pugliese et al., 2024)—we examine, in a women-only sample, whether post-traumatic stress symptoms (re-experiencing, avoidance, hyperarousal), disturbances in self-organization (affective dysregulation, negative self-concept, relational disturbances), and dissociative symptoms account for interpersonal problems linked to IPV victimization and perpetration.

Drawing on the critical synthesis by Pugliese and colleagues (Pugliese et al., 2023; Pugliese et al., 2024), we specify two parallel mediation hypotheses with early relational trauma as the predictor. In the model predicting victimization-related interpersonal problems, we expect PTSD symptom clusters to operate as the principal mediator (H1). In the model predicting perpetration-related interpersonal problems, we expect disturbances in self-organization (DSO) to function as the principal mediator (H2). Across both models, we further expect dissociation to act as an additional

mediator, linking early trauma to both victimization- and perpetration-related difficulties (H3).

## Methods

### Sample

The required sample size was calculated using GPower\* (version 3.1) to ensure sufficient statistical power for a mediation model with one predictor, three mediators, and one outcome variable. We selected the F-test family, using the linear multiple regression: increase in  $R^2$  test. Parameters were set to a medium effect size ( $f^2 = 0.15$ ),  $\alpha = 0.05$ , and power = 0.80, as recommended by Cohen (2013). The number of tested predictors was 4. This analysis yielded a minimum required sample size of 85 participants. Our final sample slightly exceeds this threshold, providing sufficient power to detect effects in the medium range. The study consisted of 98 female participants from the general population, aged 18-60 years ( $M = 33.0$ ,  $SD = 8.25$ ). 1% of the sample had a middle school diploma, 24,5% a bachelor's degree, 32,7% a master's degree, and 21,4% a postgraduate degree. 75,5% of the sample comprises nubile women, 23,5% are married, and 1% are widowed. Most participants identified as heterosexual (79.6%), followed by bisexual (11.2%) and homosexual (5.1%); the remaining (4.1%) were grouped as other/unspecified (e.g., pansexual, undefined). Inclusion criteria were: age 18 or older, education level of secondary school or higher, and easy access to the Internet connection. Participants who declared in the demographic form that they had a diagnosis of a disorder in the psychotic area were excluded from the sample.

### Procedure

The participants, recruited from the general population, completed a survey lasting about 30 minutes. Recruitment took place through a non-probabilistic convenience sampling method which included both word of mouth and sharing information about the study on social networks (e.g., Facebook and Instagram) and an instant messaging application (i.e., WhatsApp). Informed consent was obtained via electronic means before survey completion. Furthermore, in compliance with Legislative Decree No. 196 of 30 June 2003, the "Personal Data Protection Code" (which adapts Italian data protection legislation to the new provisions of the GDPR, 2003) guaranteed the participants' anonymity. Before accessing the standardized questionnaire part, participants completed a demographic form, which included requesting information regarding age, nationality, educational qualification, marital status, and the presence of psychological or psychiatric diagnosis. The study received approval from the Ethical Committee (approval number: 112024), and was conducted following the ethical standards of the relevant national and institutional committees on human experimentation and the Helsinki Declaration of 1975, revised in 2013.

### Measures

The Childhood Trauma Questionnaire Short-Form (CTQ-SF; Bernstein et al., 2003; Sacchi et al., 2018) is one of the most widely used retrospective measures for assessing trauma exposure history. The CTQ-SF consists of 28 items regarding experiences

of trauma while growing up, rated on a 5-point Likert scale (1 "never true" - 5 "very often true"). The self-report questionnaire consists of five clinical subscales: Physical Abuse, Emotional Abuse, Sexual Abuse, Physical Neglect, and Emotional Neglect. In addition, three items assess Minimization, i.e., participants' tendency to minimize or deny negative childhood experiences. Sample items of CTQ-SF are "I knew that there was someone to take care of me and protect me", "People in my family said hurtful or insulting things to me", and "I believe that I was sexually abused". In the Italian validation study, Cronbach's  $\alpha$  ranged between .88 and .96 for the five subscales, while in the present study it was .93 for the total scale (all items combined) the present study, it was .93 considering the five subscales, and .89 for the Minimization subscale.

The International Trauma Questionnaire (ITQ; Cloitre et al., 2018; Italian validation by Rossi et al., 2022) was used to assess PTSD and CPTSD according to the ICD-11 diagnostic criteria. It consists of a self-report measure that asks participants to rate PTSD clusters consisting of Re-experiencing, Avoidance, and Hyperarousal in the past month about a past traumatic event. In addition, participants were asked to rate the presence of symptoms contained in the DSO cluster consisting of Affective Dysregulation, Negative Self-Concept, and Disturbances in Relationships. These questions relate to both how the participant perceives themselves and to other people, including how much they feel these symptoms have impaired their functioning in the past month. All ITQ items are based on a 5-point Likert response scale in which 0 corresponds to "not at all" and 5 to "extremely" about the presence of PTSD and cPTSD symptoms. In the Italian validation, Cronbach's  $\alpha$  was .88 for both the PTSD and DSO subscales, while in our sample, it was .79 for the PTSD scale and .81 for the DSO scale.

The Inventory of Interpersonal Problems IIP-32 (Horowitz et al., 1979; Italian validation by Lo Coco et al., 2018) is a 32-item questionnaire of distressing interpersonal behaviors that the participant rates as "hard to do" (i.e., behavioral inhibitions) or "does too much" (i.e., behavioral excesses). Items are rated on a 0-4 Likert scale (0 = not at all; 4 = extremely), with respondents indicating—for "hard to do" items—how burdensome/difficult the problem is for them, and—for "does too much" items—how much they tend to enact that behavior excessively. It is divided into eight subscales: Domineering/Controlling; Vindictive/ Self-centered; Cold/ Distant; Socially Inhibited/Avoidant; Non-assertive; Overly Accommodating/Exploitable; Self-sacrificing/Overly nurturant; Intrusive/Needy. IIP-32 also provides a total scale score. In the Italian validation study, the value of  $\omega$  was .98 for the total score, while in our sample, it was .85.

The Dissociative Experiences Scale DES-II (Bernstein & Putnam, 1986; Garofalo et al., 2015) is a self-report questionnaire consisting of 28 items, rated on an 11-point scale. It assesses three dissociative experiences: 1) absorption experiences, ("Some people have the experience of being accused of lying when they do not think that they have lied"); 2) amnesia experiences, ("Some people have the experience of finding themselves dressed in clothes that they don't remember putting on"); and 3) depersonalization-derealization experiences, ("Some people have the experience of looking in a mirror and not recognizing themselves"). Participants must indicate the percentage of time (between 0 and 100%) in which they lived the experience described. DES-II showed good internal consistency in the Italian validation (Cronbach's  $\alpha =$

.90), and the total scale used in the present study had an  $\alpha$  of .94.

### Operational definition of interpersonal risk phenotypes

Interpersonal functioning is conceptually organized along two dimensions: the dimension of affiliation, nurturance, or communion, which ranges from hostile to friendly behavior, and the dimension of control, dominance, or influence, which ranges from yielding to dominant behavior (Horowitz et al., 2004). In this study, we considered dominant-hostile behaviors as indicators of perpetration risk and submissive-friendly behaviors as indicators of victimization risk. This distinction is supported by research showing that hostile and controlling interpersonal styles are strongly associated with IPV perpetration, often mediating the relationship between childhood maltreatment and later violent behaviors (Gilbar et al., 2020; Stappenbeck et al., 2023). More broadly, interpersonal problems tend to emerge early, consolidate by adolescence, and constitute a frequent target in psychotherapy and a core dimension of personality disturbance (Monsen et al., 2006; Murphy & Blumenthal, 2000), with attachment insecurities prospectively linked to specific interpersonal difficulties (Lawson, 2008). A composite at the hostile-dominant pole—hostile dominant interpersonal problems (HDIP)—has been repeatedly tied to IPV severity and psychological aggression, anger, and a history of interparental violence (Lawson, 2008; Lawson & Brossart, 2009; Murphy et al., 2007). Crucially, in male partner-abuser samples, HDIP mediated the link between avoidant attachment and IPV (violence severity and psychological aggression), whereas borderline/antisocial features did not, underscoring the centrality of hostile-dominant interpersonal style in perpetration (Lawson & Malnar, 2011; Lawson & Brossart, 2013). Conversely, submissive and compliant interpersonal styles have been linked to difficulties in asserting boundaries, increased vulnerability, and a higher likelihood of experiencing coercion or abuse (Bayraktar et al., 2015; Sierra et al., 2021). The IIP-32 questionnaire has previously been employed as a tool to investigate interpersonal difficulties typically associated with exposure to early relational trauma, distinguishing between experiences of victimization and perpetration (Lawson & Brossart, 2013; Skorheim & Anderson, 2025). In the present study, we adopted this instrument to examine victimization and perpetration as potential outcomes emerging from the same traumatic experiences. Therefore, in our study we used the label “IIP Perp” to mean the sum of the subscales Domineering/Controlling, Vindictive/Self-centered, Cold/Distant, and Socially Inhibited/Avoidant, while “IIP Vict” for the sum of the subscales Non-Assertive, Overly Accommodating/Exploitable, Self-sacrificing/Overly Nurturant and Intrusive/Needy. This operationalization aligns our perpetration proxy with the hostile-dominant quadrant emphasized in prior IPV studies, while our victimization proxy captures friendly-submissive/interpersonally compliant tendencies that are theoretically linked to boundary vulnerabilities.

### Statistical analyses

Statistical analyses were conducted using the Jamovi software version 2.3.28. All data were initially screened for missing data and outliers. A series of descriptive

analyses was estimated for all variables included in the study. The normal distribution of data was assessed using skewness and kurtosis. Pearson’s correlation coefficients were computed to examine the associations among the variables employed in the study. We derived an overall maltreatment factor from the five clinical subscales of the Childhood Trauma Questionnaire (CTQ)—Emotional Abuse, Physical Abuse, Sexual Abuse, Emotional Neglect, and Physical Neglect (Minimization/Denial excluded). We conducted an exploratory factor analysis (EFA) on the five subscale scores using principal axis factoring with no rotation. Factor retention was based on eigenvalues and the scree plot and cross-checked with a parallel analysis, which supported a single-factor solution. Standardized factor scores were then generated using the regression (Thurstone) method; higher values indicate greater overall maltreatment severity. This analytic choice is theoretically grounded in dimensional models of developmental trauma that emphasize cumulative burden and severity across multiple interpersonal adversities—rather than discrete, non-overlapping categories—as the most informative representation of early maltreatment (Farina & Schimmenti, 2025; Schimmenti, 2018). Accordingly, a single latent factor provides a parsimonious, theory-consistent index of overall child maltreatment exposure.

Two mediation models were then estimated to analyze the mediating role of post-traumatic symptoms (post-traumatic stress disorder, disturbances in self-organization, and dissociative symptoms) in the relationship between early traumatic experiences and specific interpersonal outcomes related to victimization problems (H1) and perpetration problems (H2). Early maltreatment was entered as the independent variable using the CTQ maltreatment factor score. Parallel mediators were the ITQ-PTSD and ITQ-DSO subscales and the DES-II total. All paths were adjusted for age and marital status (covariates), and 95% bias-corrected bootstrap confidence intervals were computed with 5,000 resamples. IIP Vict (Non-assertive, Overly Accommodating/Exploitable, Self-sacrificing/Overly nurturing, Intrusive/Needy) and IIP Perp (Domineering/Controlling, Vindictive/Self-centered, Cold/Distant, Socially Inhibited/Avoidant) were included as dependent variables, respectively.

### Results

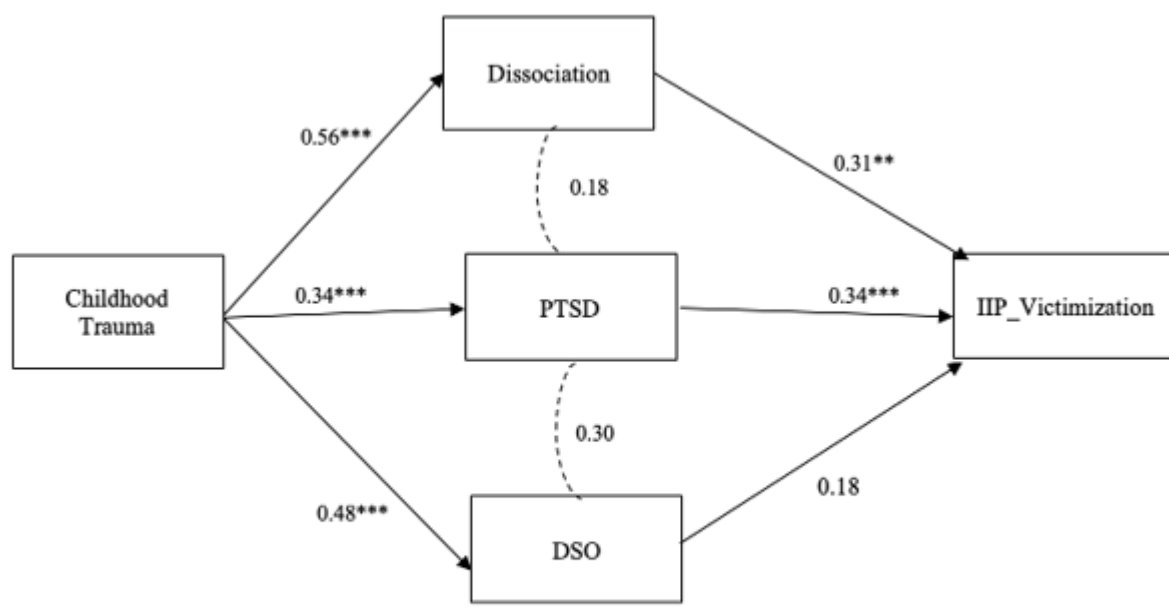
Descriptive statistics are reported in **table 1**. All variables were approximately normally distributed (skewness and kurtosis < 1). To obtain a global index of childhood maltreatment, we conducted an exploratory factor analysis on the five CTQ clinical subscales. Sampling adequacy was good (KMO = .819), and Bartlett’s test was significant,  $\chi^2(10) = 209$ ,  $p < .001$ . A single-factor solution was supported (eigenvalue<sub>1</sub> = 2.67; subsequent eigenvalues  $\approx 0$ /negative), explaining 53.4% of the variance. Standardized loadings were: Emotional Abuse = .894, Emotional Neglect = .839, Sexual Abuse = .723, Physical Neglect = .680, and Physical Abuse = .427 (uniqueenesses .201, .296, .477, .538, .817, respectively). Regression-based factor scores (higher = greater maltreatment severity) were saved and used in subsequent analyses. As shown in **table 2**, all variables are significantly interrelated, with particularly strong associations among trauma-related and psychopathological measures. CTQ shows moderate positive correlations with PTSD, DSO symptoms, and dissociation. Dissociation is significantly correlated with

all variables, suggesting its central role in the studied constructs. Both victimization-like and perpetration-like interpersonal problems show moderate correlations with trauma-related symptoms and dissociation, with IIP\_Perp being particularly associated with DSO ( $r = .594^{***}$ ).

Two mediation models were estimated to investigate the mediation effect of post-traumatic symptoms (PTSD), disturbances in self-organization (DSO), and dissociative symptoms (DES-II) in the relationship between early traumatic experiences (CTQ) and interpersonal problems related to victimization (IIP\_Vict) and perpetration (IIP\_Perp), respectively. **Figure 1** depicts the first model. As shown in **table 3**, the CTQ maltreatment factor positively predicted PTSD symptoms ( $\beta = .34, p < .001$ ), DSO ( $\beta = .48, p < .001$ ), and dissociation (DES-II;  $\beta = .56, p < .001$ ). In turn,

PTSD ( $\beta = .35, p < .001$ ) and dissociation ( $\beta = .31, p = .003$ ) significantly predicted victimization-related interpersonal problems (IIP\_Vict), whereas DSO did not ( $\beta = .18, p = .060$ ). Indirect effects from maltreatment to IIP\_Vict were significant via PTSD ( $\beta = .12$ ; BC 95% CI [0.39, 1.90];  $p = .010$ ) and via dissociation ( $\beta = .17$ ; BC 95% CI [0.53, 2.83];  $p = .006$ ), but not via DSO ( $\beta = .09$ ; BC 95% CI [-0.01, 1.71];  $p = .075$ ). The direct path from childhood maltreatment to IIP\_Vict was not significant ( $\beta = -.09, p = .402$ ), whereas the total effect was ( $\beta = .30, p = .003$ ). This pattern indicates a full mediation effect, whereby the association between childhood trauma and victimization-related interpersonal problems is entirely accounted for by PTSD symptoms and dissociation. Age showed small, nonsignificant associations with PTSD ( $\beta = -.05, p = .38$ ), DSO ( $\beta = -.07, p = .24$ ), dissociation ( $\beta = -.06, p$

**Figure 1.** Mediation model for victimization problems



Note: Dashed lines denote covariances. Confidence intervals use a bias-corrected bootstrap (5,000 resamples). All paths are adjusted for age and marital status. Betas are completely standardized.  
\*  $p < .05$ , \*\*  $p < .01$ , \*\*\*  $p < .001$

IIP\_Victimization = Inventory of Interpersonal Problems (sum of Non-Assertive, Overly Accommodating/Exploitable, Self-sacrificing/Overly Nurturant, Intrusive/Needy)

**Table 1.** Descriptive statistics, Coefficient alpha, omega, and skewness and kurtosis values across study variables

Variable	$\alpha$	$\omega$	M	SD	Min.	Max.	Skew	Kurtosis
CTQ	.93	.93	7.56	0.94	-1.21	2.50	.59	-.45
ITQ_PTSD	.79	.79	12.8	4.95	0	22	-.38	-.26
ITQ_DSO	.81	.82	10.7	5.52	1	24	.47	-.36
DES_TOT	.94	.94	25.7	16.7	0	71.8	.91	.08
IIP_Vict	.81	.82	37.9	8.09	22	56	.19	-.66
IIP_Perp	.82	.83	28.4	7.36	16	47	.47	-.20

Note. CTQ—Global maltreatment factor (EFA-based standardized factor score; higher = greater severity; negative values indicate below-mean levels);  $\alpha/\omega$  computed on the subscales.

CTQ = Childhood Trauma; ITQ\_PTSD = Post-Traumatic Stress Disorders Symptoms; ITQ\_DSO = Disturbances in Self-Organization (Affective Dysregulation, Negative Self-Concept, Disturbances in Relationships); DES\_TOT = Dissociative Experiences Scale\_Total Score; IIP\_Vict = Inventory of Interpersonal Problems (sum of Non-Assertive, Overly Accommodating/Exploitable, Self-sacrificing/Overly Nurturant, Intrusive/Needy); IIP\_Perp = Inventory of Interpersonal Problems (sum of Domineering/Controlling, Vindictive/Self-centered, Cold/Distant, Socially Inhibited/Avoidant);

**Table 2.** Pearson's correlation between the scores provided by the administered tools

Variable	CTQ	ITQ_PTSD	ITQ_DSO	DES_TOT	IIP_Vict	IIP_Perp
CTQ	-					
ITQ_PTSD	.336***	-				
ITQ_DSO	.491***	.417***	-			
DES_TOT	.571***	.427***	.405***	-		
IIP_Vict	.287**	.520***	.397***	.472***	-	
IIP_Perp	.491***	.278**	.594***	.503***	.31**	-

Note: \*\*\* p<.001, \*\* p<.01

CTQ = Childhood Trauma; ITQ\_PTSD = Post-Traumatic Stress Disorders Symptoms; ITQ\_DSO = Disturbances in Self-Organization (Affective Dysregulation, Negative Self-Concept, Disturbances in Relationships); DES\_TOT = Dissociative Experiences Scale\_Total Score; IIP\_Vict=Inventory of Interpersonal Problems (sum of Non-Assertive, Overly Accommodating/Exploitable, Self-sacrificing/Overly Nurturant, Intrusive/Needy); IIP\_Perp = Inventory of Interpersonal Problems (sum of Domineering/Controlling, Vindictive/Self-centered, Cold/Distant, Socially Inhibited/Avoidant).

**Table 3.** Mediation model for victimization problems: indirect and total effects

Type	Effect	Estimate	SE	95% Lower	95% Upper	C.I.	β	z	p
Indirect	CTQ PTSD IIP_Vict	1.00	0.39	0.39	1.90		0.12	2.56	.010
	CTQ DSO IIP_Vict	0.76	0.43	-0.01	1.71		0.09	1.78	.075
	CTQ DES IIP_Vict	1.50	0.54	0.52	2.83		0.17	2.76	.006
Component	CTQ PTSD	1.78	0.50	0.85	2.73		0.34	3.54	<.001
	PTSD IIP_Vict	0.56	0.15	0.27	0.85		0.34	3.71	<.001
	CTQ DSO	2.83	0.51	1.92	3.82		0.48	5.51	<.001
	DSO IIP_Vict	0.27	0.14	-0.02	0.562		0.18	1.88	.060
	CTQ DES	9.99	1.48	6.71	13.12		0.56	6.75	<.001
Direct	DES IIP_Vict	0.15	0.05	0.049	0.25		0.31	3.02	.003
	CTQ IIP_Vict	-0.72	0.89	-2.74	1.51		-0.08	-0.81	.419
Total	CTQ IIP_Vict	2.54	0.84	0.579	4.58		0.30	3.02	.003

Note. Effects are standardized (β). Indirect = CTQ → mediator → outcome; Component = constituent paths; Direct = CTQ → outcome; Total = Direct + sum of indirects. 95% bias-corrected bootstrap CIs (5,000 resamples). All paths adjusted for age and marital status.

CTQ = Childhood Trauma; ITQ\_PTSD = Post-Traumatic Stress Disorders Symptoms; ITQ\_DSO = Disturbances in Self-Organization (Affective Dysregulation, Negative Self-Concept, Disturbances in Relationships); DES\_TOT = Dissociative Experiences Scale\_Total Score; IIP\_Vict=Inventory of Interpersonal Problems (sum of Non-Assertive, Overly Accommodating/Exploitable, Self-sacrificing/Overly Nurturant, Intrusive/Needy); IIP\_Perp = Inventory of Interpersonal Problems (sum of Domineering/Controlling, Vindictive/Self-centered, Cold/Distant, Socially Inhibited/Avoidant).

= .73), and IIP\_Vict (β = -.05, p = .59). Marital status also showed small, nonsignificant paths to PTSD (β = .02, p = .87), DSO (β = .11, p = .26), dissociation (β = .07, p = .45), and IIP\_Vict (β = -.05, p = .66). None of the indirect paths via age or marital status were significant (all BC 95% CIs included zero), and adjusting for these covariates did not alter the pattern, magnitude, or significance of the primary effects.

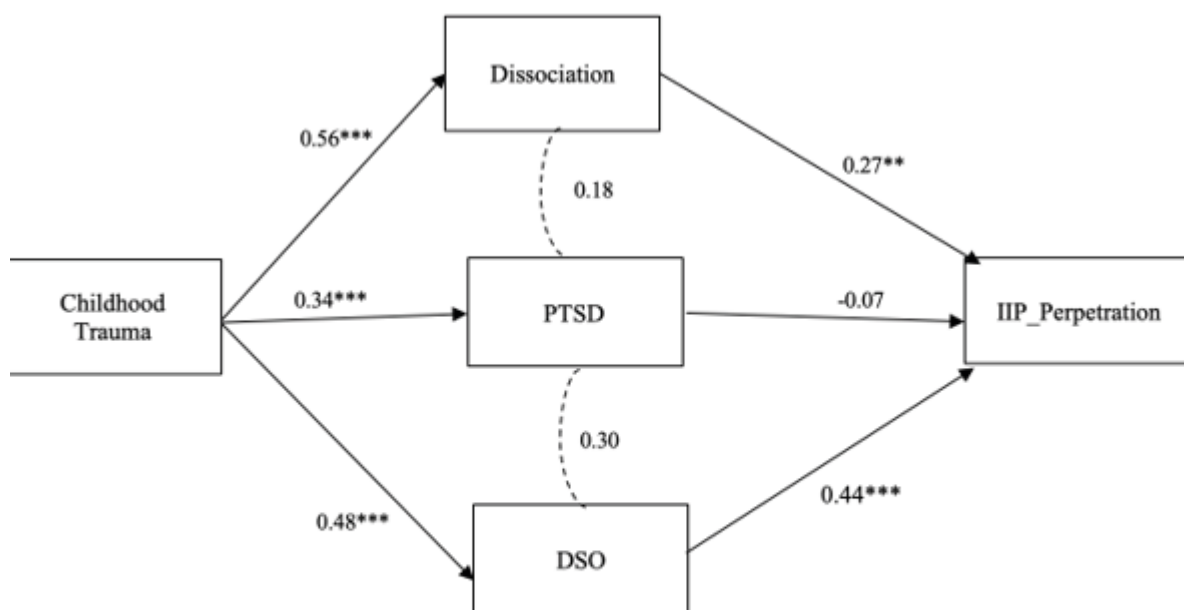
Figure 2 shows the model with IIP\_Perp as outcome (BC bootstrap 5,000; 95% CIs). As reported in table 4, the CTQ maltreatment factor positively predicted DSO (β = .48, p < .001), dissociation (DES-II; β = .56, p < .001), and PTSD (β = .34, p < .001). In turn, DSO (β = .44, p < .001) and dissociation (β = .27, p = .005) significantly predicted IIP\_Perp, whereas the path from PTSD to IIP\_Perp was not significant (β = -.07, p = .433). Indirect effects from maltreatment to IIP\_Perp were significant via DSO (β = .21, p < .001; BC 95% CI excluded 0) and via dissociation (β = .15, p = .009; BC 95% CI excluded 0), but not via PTSD (β = -.02, p = .435). The direct effect of

maltreatment on IIP\_Perp was not significant (β = .14, p = .161), whereas the total effect was (β = .48, p < .001). Accordingly, the results support a full mediation model in which the relationship between childhood trauma and perpetration-related interpersonal problems is fully mediated by disturbances in self-organization and dissociative symptoms. Age showed small, non-significant paths to PTSD (β = -.07, p = .386), DSO (β = -.15, p = .124), dissociation (β = -.06, p = .524), and IIP\_Perp (β = -.07, p = .493). Marital status likewise showed small, non-significant paths to PTSD (β = .02, p = .874), DSO (β = .11, p = .259), dissociation (β = .07, p = .453), and IIP\_Perp (β = .03, p = .698). Including these covariates did not change the pattern, magnitude, or significance of the primary effects.

## Discussion

In this study, we examined how childhood relational trauma contributes to two distinct interpersonal risk

Figure 2. Mediation model for perpetration problems



Note: Dashed lines denote covariances. Confidence intervals use a bias-corrected bootstrap (5,000 resamples). All paths are adjusted for age and marital status. Betas are completely standardized.  
 \*  $p < .05$ , \*\*  $p < .01$ , \*\*\*  $p < .001$

IIP Perpetration = Inventory of Interpersonal Problems (sum of Domineering/Controlling, Vindictive/Self-centered, Cold/Distant, Socially Inhibited/Avoidant).

Table 4. Mediation model for perpetration problems: indirect and total effects

Type	Effect	Estimate	SE	95% Lower	95% Upper	C.I.	$\beta$	z	p
Indirect	CTQ PTSD IIP_Perp	-0.18	0.23	-0.62	0.23	-0.02	-0.76	.444	
	CTQ DSO IIP_Perp	1.67	0.46	0.88	2.92	0.21	3.63	<.001	
	CTQ DES IIP_Perp	1.19	0.46	0.38	2.30	0.15	2.59	.009	
Component	CTQ PTSD	1.78	0.50	0.90	2.76	0.34	3.54	<.001	
	PTSD IIP_Perp	-0.10	0.13	-0.31	0.14	-0.07	-0.78	.433	
	CTQ DSO	2.83	0.51	1.92	3.82	0.48	5.51	<.001	
	DSO IIP_Perp	0.59	0.12	0.34	0.85	0.44	4.83	<.001	
	CTQ DES	9.99	1.48	6.58	13.01	0.56	6.75	<.001	
	DES IIP_Perp	0.12	0.04	0.03	0.20	0.27	2.81	.005	
Direct	CTQ IIP_Perp	1.06	0.76	-0.56	2.47	0.13	1.39	.165	
Total	CTQ IIP_Perp	3.74	0.69	2.61	5.04	0.48	5.39	<.001	

Note. Effects are standardized ( $\beta$ ). Indirect = CTQ  $\rightarrow$  mediator  $\rightarrow$  outcome; Component = constituent paths; Direct = CTQ  $\rightarrow$  outcome; Total = Direct + sum of indirects. 95% bias-corrected bootstrap CIs (5,000 resamples). All paths adjusted for age and marital status.

CTQ = Childhood Trauma; ITQ PTSD = Post-Traumatic Stress Disorders Symptoms; ITQ DSO = Disturbances in Self-Organization (Affective Dysregulation, Negative Self-Concept, Disturbances in Relationships); DES\_TOT = Dissociative Experiences Scale Total Score; IIP Vict = Inventory of Interpersonal Problems (sum of Non-Assertive, Overly Accommodating/Exploitable, Self-sacrificing/Overly Nurturant, Intrusive/Needy); IIP\_Perp = Inventory of Interpersonal Problems (sum of Domineering/Controlling, Vindictive/Self-centered, Cold/Distant, Socially Inhibited/Avoidant).

profiles—vulnerability to IPV victimization-like and perpetration-like patterns—through specific trauma-related mediating processes. Specifically, we tested whether post-traumatic stress symptoms, disturbances in self-organization (DSO), and dissociation differentially mediate the relationship between early trauma and these profiles. Our findings support a model in which trauma does not directly lead to interpersonal dysfunction, but operates through distinct symptom configurations that shape relational strategies in different ways. This study contributes to the understanding of these dynamics in women, filling a gap in the literature focused on men IPV perpetrators (Langhinrichsen-Rohling et al., 2012; Swan et al., 2005).

Results of correlation analyses showed distinct associations between trauma-related variables and interpersonal difficulties. Specifically, childhood maltreatment was moderately correlated with PTSD, DSO, and dissociation, confirming its central role as an antecedent of trauma-related psychopathology. Dissociation showed significant associations with all variables, suggesting its transdiagnostic function as a potential bridge between early traumatic experiences and interpersonal problems in adulthood. Regarding interpersonal functioning, victimization-like problems (IIP\_Vict) were strongly correlated with PTSD symptoms and dissociation, while perpetration-like problems (IIP\_Perp) were most strongly associated with DSO.

At the same time, a more nuanced interpretation of these findings is warranted. Although DSO was most robustly linked to perpetration-like interpersonal problems, it also showed a moderate association with victimization-like difficulties ( $r = .397$ ), suggesting that disturbances in self-organization may contribute more broadly to relational vulnerability rather than being exclusively tied to perpetration-related dynamics. This overlap is theoretically consistent with trauma-based models positing that affective dysregulation, negative self-concept, and relational insecurity can manifest in different interpersonal strategies depending on contextual and relational contingencies (Liotti & Farina, 2012). More specifically, trauma-developmental and dissociation-based models emphasize that disturbances in self-organization (DSO) are not merely intrapsychic phenomena but are deeply embedded in maladaptive interpersonal strategies shaped by traumatic relational experiences. From this perspective, dysfunctional interpersonal patterns may be understood as adaptive survival strategies that emerge within chronically threatening attachment contexts and subsequently generalize across relational environments.

Thus, the observed pattern is better understood as reflecting partially overlapping but functionally differentiated associations rather than mutually exclusive victimization versus perpetration pathways. PTSD symptoms and dissociation appear more closely linked to submissive–friendly interpersonal behaviors related to victimization, whereas DSO emerges as more prominently connected to dominant–hostile interpersonal behaviors underlying perpetration. Building on this correlational evidence, the mediation analyses further clarified how these trauma-related symptom clusters differentially contribute to IPV victimization-like and perpetration-like trajectories.

Taken together, the mediation results support a differentiated process model linking childhood trauma to distinct interpersonal risk profiles. Specifically, PTSD symptoms and dissociation appear to mediate pathways toward victimization-like profiles, characterized by submissive and vulnerability-related

interpersonal patterns. In contrast, DSO primarily mediate pathways toward perpetration-like profiles, reflecting more externalizing, and dominance-related relational strategies. Dissociation, in turn, emerges as a transdiagnostic mediator operating across both pathways, suggesting that it may function as a general mechanism of disconnection that facilitates both vulnerability to victimization and engagement in aggressive behaviors, depending on contextual and relational factors.

### IPV victimization-like trajectory

Results showed that both PTSD symptoms (Pugliese et al., 2024) and dissociative symptoms mediate the relationship between early traumatic experiences and victimization problems (Ford & Courtois, 2014), while the effect of DSO was not significant. The relation between early traumatic experiences and post-traumatic symptoms has been widely demonstrated, specifically focusing on the alteration at the psychological, biological, neurological, physiological, and behavioral levels within the IPV context (Dutton, 2007). Despite this, the mechanisms through which trauma-related symptoms shape vulnerability-related interpersonal functioning remain partly unexplored (Rauer & El-Sheikh, 2012) and emotional numbing (Birkley et al., 2016) represent specific predisposing factors in enduring violence. The mediation role of PTSD in the relationship between childhood experiences and IPV victimization in women may be explained with the dissociation as a specific short term protective mechanism from abusive experiences. This may increase the risk of revictimization in the long term period (Lanius et al., 2011; Noll et al., 2003; Zamir et al., 2018).

### IPV perpetrations-like trajectory

Concerning IPV perpetration-like problems in women, a mediating role of DSO (versus PTSD) emerged. This result highlights the role of DSO in shaping externalizing and control-oriented interpersonal profiles associated with perpetration risk in women, confirming previous results in male samples (Gilbar et al., 2020; Pugliese et al., 2024). Previous findings showed that DSO symptoms were more strongly associated with men who perpetrate violence (Gilbar & Ford, 2020), whereas BPD symptoms—such as externalized hostility—were more frequently observed in violent women (Goldenson et al., 2009; Stuart et al., 2006). Our study extends these results by providing preliminary evidence that DSO symptoms may also represent a risk factor for the development of abusive behaviors in women. Consistent with recent work, facets of DSO— affective dysregulation (particularly anger surges), negative self-concept/shame, and relational mistrust/hostility—map onto mechanisms that can fuel coercive control and reactive aggression under attachment threat (Ciringione et al., 2025). Taken together, these data suggest that cPTSD-related DSO symptoms warrants systematic screening in women at risk for IPV perpetration and may represent a mechanistic target for intervention (e.g., emotion regulation, shame processing, mentalizing/boundary work). In this regard, trauma-focused interventions such as Imagery Rescripting (ImRs) have shown promising efficacy in addressing trauma-related symptoms, including both PTSD and complex PTSD presentations, by targeting maladaptive meanings, emotional regulation, and unmet

relational needs (Visco-Comandini et al., 2025). This approach may be particularly relevant for addressing DSO-related processes, such as shame, negative self-concept, and relational expectations.

## Dissociation as a transdiagnostic factor in IPV

Consistent with prior research, dissociation appears to play a cross-cutting role in IPV. This symptom may be a non-specific factor linked to both victimization and perpetration in IPV. According to our results, dissociation indifferently mediates the relationship between early traumatic experiences and both perpetration-like and victimization-like behaviors. This data confirm results from the clinical population (Krause-Utz et al., 2023). The specific role that dissociation may play in IPV remains still uncertain. It is possible that, in victimization, dissociation functions as a learned survival mechanism to the abuse endured. This may increase the risk of re-victimization by impairing the individual's ability to perceive the severity of violence, and underestimating the associated risks for life and inhibiting the ability to seek help. Conversely, in IPV perpetration, dissociation may serve as a mechanism to protect the individual from primary intolerable emotions (e.g. shame, guilt, or fear of abandonment/loneliness), underlying the secondary emotions that are more acceptable (e.g. anger). These emotions may drive abusive behaviors. Alternatively, it might act as a defense mechanism to shield the individual from the moral judgment and emotional consequences of their violent behaviors. This is also in line with the idea that underlying the perpetration of violence might be an over-regulation of dependency needs that underlies an intense fear of intimacy (Papa et al., 2024).

These findings further support the idea that dissociation does not operate in a pathway-specific manner, but rather functions as a general mediator linking early trauma to different interpersonal outcomes, depending on how other regulatory processes are organized.

## Limitations

This study has several limitations that should be considered when interpreting the findings. First, other mechanisms potentially influencing the relationship between trauma and interpersonal problems were not examined. Specifically, cognitive mechanisms such as metacognitive difficulties arising from trauma (e.g., challenges in integrating traumatic experiences into one's sense of self), and relational coping strategies – like the role of symptom minimization – were not included in our analyses. In addition, the study did not collect data on the presence or absence of violent relationships, which may have added valuable context to interpreting the participants' behaviors and experiences. Relatedly, we did not assess whether participants were currently in an intimate relationship at the time of data collection; this information could have provided additional context for interpreting the findings. Nonetheless, our primary objective was to examine the role of traumatic symptoms in adult interpersonal difficulties irrespective of current relationship status. Understanding whether participants were actively involved in violent dynamics at the time of assessment would contribute to a more nuanced perspective on the observed patterns of victimization-like and perpetration-like. In addition, a small sample size may lead to inaccurate effect estimates, as it may be unrepresentative and limit the generalizability of the

results.

A further limitation concerns the generalizability of our findings. Because our study relied on a community sample and self-report measures of IPV-related risk, results should be interpreted as reflecting risk factors and profiles rather than actual experiences of victims or perpetrators. Future research in clinical and forensic samples is needed to validate and extend these findings.

Finally, our cross-sectional design limits the ability to infer causal relationships between trauma, IPV-like behaviors. Although the research offers interesting perspectives on the relationship between trauma and interpersonal problems, its findings should be considered preliminary and serve primarily as a foundation for longitudinal studies that can determine the directionality of these relationships, with more representative samples and more sophisticated methodologies. Despite the study's limitations, the findings provide valuable insights for future research on trauma and interpersonal problems.

## Conclusion

This research represents a step forward in understanding traumatic factors that contribute to interpersonal problems, including both victimization-like and perpetration-like. Converging evidence from both correlation and mediation analyses indicates that PTSD symptoms are primarily associated with an increased risk of victimization, whereas DSO symptoms are more closely related to the risk of perpetration of violence. Dissociation emerges as a transdiagnostic factor underlying both outcomes.

The results obtained in the present work highlight some valuable implications for the prevention of interpersonal violence. First, it is crucial to differentiate trauma symptoms in the context of victimization-like and perpetration-like problems. This differentiation should guide clinicians in understanding psychological risk factors of IPV, such as DSO, PTSD, and dissociation. In addition, the results underscore the cross-cutting role of dissociation in interpersonal problems.

Overall, the findings support a process-based model in which childhood trauma contributes to distinct interpersonal risk profiles through partially differentiated mediating mechanisms. Rather than representing separate categories, victimization-like and perpetration-like patterns may reflect alternative regulatory outcomes shaped by the interplay between PTSD symptoms, DSO, and dissociation.

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