

Treatment of Danish Survivors of Childhood Sexual Abuse

Research Briefing

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2017



Overview

This research briefing is based on a number of inter-related research objectives, funded by the Danish Victims' Foundation (www.offerfonden.dk). In recent years there has been growing interest in public health campaigns designed to increase awareness of childhood sexual abuse (CSA) and develop appropriate treatment interventions that help survivors deal with an array of negative consequences that often follow. CSA is a robust predictor of adult psychiatric disorders, including mood and anxiety disorders, substance dependence, post-traumatic stress disorder and psychosis. CSA has also been associated with a range of physical health problems, sexual disorders, sexual risk behaviour, re-victimization, intimate partner violence, lower educational levels and income. The relationship between CSA and adult psychopathology, poor social and occupational outcomes is further complicated by the influence of a variety of demographic factors (e.g. gender and age of abuse onset) and abuse characteristics (e.g. duration, number of abusive acts, number of abusers).

Estimates of CSA vary substantially, however, a global estimated prevalence of CSA was reported as 11.8% (Stoltenborgh, van IJzendoorn, Euser, & Bakermans-Kranenburg, 2011). A meta-analysis conducted in Nordic countries revealed a prevalence of CSA between 3–23% for boys and 11–36% for girls (Kloppen, Haugland, Svedin, Mæhle, & Breivik, 2016). A recent review concluded that psychological treatment of CSA has a moderate effect on most of the outcome domains. A number of limitations were presented such as small sample sizes, over-representation of female survivors and short follow-up periods. We intended to build upon these limitations and examine the long-term psychological consequences of CSA using a sample of 484 male and female survivors that were assessed over an 18-month period.

This research used prospective data from adult survivors of CSA across three main areas in Denmark; the capital, regions South and Mid-North. The location of the study within Denmark means that it is particularly well-placed to inform policy and practice. Prevention, early detection, and treatment of CSA are all highly prioritised governmental goals. The project aimed to examine treatment effects in a large sample of CSA survivors in Denmark, by assessing demographic, abuse related characteristics, and a range of outcomes. Sexual trauma variables were based on 18 questions relating to; **non-contact** (e.g., had to listen to other's sexual experiences, proposals or threats about taking part in sexual acts, watch someone present their genitals, watch adult intercourse or pornographic material, present own genitals to someone else), **non-penetrative contact** (e.g., genital contact, had to masturbate

while someone was watching, reciprocal masturbation), and **penetrative contact** (attempted, oral, anal, and genital intercourse).

We also used a range of standardised well-validated measures of psychopathology, traumatic symptoms, adult attachment, coping styles and perceived social support. The project has contributed to the international literature base on risk factors and the longitudinal course of outcomes associated with CSA, subsequently contributing to the development of effective policy and practice to improve outcomes for survivors.

Methodology

Participants

Participants were all survivors of childhood sexual abuse that attended four now three different Danish treatment centres for victims of CSA. The majority of participants were women (86%) and all were Caucasian. All attendees presented with distress and impairment resulting from their traumatic abuse history and received psychotherapy of an eclectic nature that suited their needs.

The mean age of the sample was 36.07 years (SD = 10.41; range 18-70). Almost all (91%) had experienced CSA before the age of 15 committed by a person at least five years older and the abuse occurred on an average of 23.47 years ago (SD = 12.30). The average age that abuse started was 6.57 years and lasted for an average of 6.88 years. The number of abusive acts reported showed that multiple victimisation was more common than a single occurrence. Only 8.5% of the participants reported that they had experienced abuse once, with 2 to 5 times (22.0%), 6 to 15 times (21.4%), 16 to 50 times (22.0%), with 51 or more times (26.4%) being more common. Almost a quarter (24.9%) of the sample reported being victimized by more than one person, with more females (27.5%) than males (10.9%) reporting this.

*Average time
since abuse
ended was
23 years*

Procedure

Treatment for CSA survivors has recently become a concern for the government in Denmark and three regional treatment centres have been established. The centres are supported by the Ministry of Social Affairs. Ethical approval for use of data gathered from this sample was obtained from the relevant university ethical boards in Denmark. Each treatment centre collaborates closely with each other and are run by volunteers. The treatment is carried out by psychologists under supervision. All of the centres complete a thorough assessment before treatment begins and it is

repeated every six months. There is no limit to the number of sessions and the treatment is free. All of the survivors receive weekly therapy; most of them on an individual basis. There is no common treatment manual. However, in the planning of the therapy all of the centres use the personality-oriented approach to treatment based on the work of Millon (1999). This treatment approach focuses on emotional regulation, relationship issues and several other treatment modalities. The most established centre has published the treatment guidelines for this approach to be used in all of the centres. Typically, the client will stay in treatment for about 1½ years, and as the therapy progresses it may be relevant to make changes to the treatment modalities

Exclusion criteria in the treatment centres were (1) evidence of intoxication at time of visit, (2) a diagnosis of a psychotic disorder, (3) self-harming behaviour, and (4) engagement in treatment elsewhere. Excluded clients are referred either to specialized institutions or to affiliated volunteer centres for treatment. When clients initially attended the treatment centre they are informed that they were asked to fill out a number of questionnaires during their first session, based on which the therapy would be planned. The therapist shared the findings with the client during the following session. The present report is based on information from the questionnaires.

Summary of Main Findings

Firstly, we assessed the prevalence of clinical syndromes¹ and personality disorders. We also examined a range of demographic (e.g., age and gender) and trauma related variables (e.g., age of abuse onset, duration of abuse) to explore which risk factors had common (or specific) effects across different diagnoses.

Table 1 Prevalence of Clinical Syndromes

Diagnosis	Frequency	Percentage
Anxiety	331	76.3
Somatoform	90	20.7
Dysthymia	173	39.9
Major Depression	161	37.1
Alcohol Dependence	24	5.5
Drug Dependence	18	4.1
Bipolar: Mania	54	12.4
Thought Disorder	76	17.5
Delusional Disorder	37	8.5

- ✚ Anxiety, dysthymia and depression were the most commonly reported disorders.
- ✚ Alcohol, substance abuse and psychotic disorders were the least commonly reported disorders.
- ✚ Females were significantly less likely to be diagnosed with alcohol dependence, drug dependence and dysthymic disorder.
- ✚ Individuals who experienced multiple abusive acts were more likely to be diagnosed with anxiety disorder, somatoform disorder, drug dependence, PTSD and major depression.
- ✚ The co-occurrence of CSA and childhood physical abuse was only associated with an increased risk for alcohol dependence (OR = 2.89).
- ✚ Females were significantly more likely to be diagnosed with somatoform disorder whereas males were more likely to be diagnosed with dysthymia and substance dependence.
- ✚ The presence of more than one abuser in childhood was the strongest predictor of adult psychopathology indicating between two-to-four times increased risk for PTSD, major depression, anxiety, somatoform, dysthymia, thought and delusional disorders.

Personality assessment is vital in treatment efficacy as it greatly affects the interaction between health professionals and the individual. The presence of personality disturbance has been associated with poorer outcomes and treatment response and premature mortality. Personality disturbance, particularly when severe, has high comorbidity with clinical disorders. Importantly, in treatment settings, clinical syndromes usually dominate the treatment plan therefore personality disturbance is frequently neglected (Tyrrer, Reed, & Crawford, 2015).

Table 2. Prevalence of DSM-5 Personality Disorders

Diagnosis	Frequency	Percentage
Schizoid	151	36
Avoidance	200	48
Dependent	268	64
Histrionic	43	10
Narcissistic	30	7
Anti-social	31	7
Compulsive	25	6
Schizotypal	66	16
Borderline	134	32
Paranoid	82	20

- ✚ Dependent, avoidant and schizoid were the most commonly reported personality disorders.
- ✚ Compulsive, antisocial and narcissistic personality disorders were the least commonly reported.
- ✚ Gender differences were only observed for avoidant personality disorders with males reporting higher levels.
- ✚ We did not find any differences between abuse specific characteristics and personality disorders

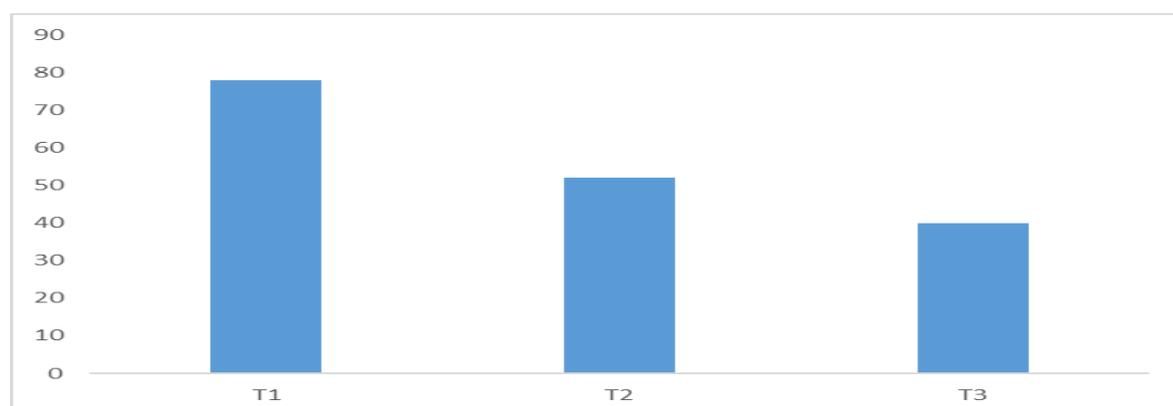
We also examined treatment effects of a range of psychological variables across a 12-month time period.^{2,3} These findings are presented in Table 3.

Table 3. Descriptive Statistics for Treatment Effects over 12-month period

	Baseline Mean (SD)	6 months Mean (SD)	12 months Mean (SD)
Trauma Symptoms	76.4 (17.0)	67.4 (20.6)	62.9 (19.2)
PTSD	16.6 (3.7)	14.89 (4.1)	13.6 (4.1)
Attachment Anxiety	20.2 (6.4)	18.6 (6.3)	18.5 (6.5)
Attachment Avoidance	38.5 (8.7)	36.0 (9.1)	35.3 (9.6)
Emotional Coping	24.9 (6.2)	22.3 (6.3)	22.0 (6.9)
Avoidant Coping	21.4 (4.4)	20.2 (4.0)	20.3 (4.9)
Self-Worth	19.2 (5.0)	20.9 (5.1)	20.3 (4.9)
Social Support	30.5 (7.4)	31.7 (14.3)	32.9 (8.3)
Trauma Cognitions	109.0 (14.5)	111.5 (14.2)	110.9
N	470	296	155

We found a steady decrease in PTSD, other trauma symptoms and insecure attachment styles over the 12-month period with a particular decline between the baseline and 6-month assessment period. In terms of maladaptive coping styles again there was a significant decline between the first six months with little change between the 6 month and 12 month assessments. Self-worth and social support increases over the 12-month period, however, trauma cognitions remained relatively stable.

Figure 1. Percentages for Decline in DSM-IV PTSD over 12-month period



Rates of Disclosure

Disclosure of sexual abuse is a complicated process that involves several domains incorporating individual, social, and cultural dimensions all of which impact the decision to disclose. Table 4 indicates that rates of disclosure were low and importantly highlight that disclosure to professionals was particularly low (e.g. police, teachers and therapists). This finding has important implications for promoting more public awareness campaigns that are targeted towards reducing stigma associated with childhood sexual abuse.

Table 4. Disclosure Rates of CSA

Disclosure	Frequency	Percentage
Mother	146	25
Friend	133	23
Partner	107	19
Therapist	90	16
Sibling	50	9
Father	43	8
Teacher	27	5
Police	7	1

Rates of Re-victimisation

Patterns of re-victimisation are very common in survivors of CSA and recent studies suggest that survivors of sexual abuse are nearly twice as likely to be re-victimised (either sexually or physically) than non-abused individuals. We examined re-victimisation and found that 85% reported that they had experienced sexual assault,

nearly 30% experienced rape and 36% reported experiencing a violent assault in the last year.

Table 5. Patterns of Re-victimisation and Co-occurring Traumatic Experiences

Traumatic Experience	Frequency	Percentage
Rape	138	29
Sexual Abuse	403	86
Violent Assault	166	36
Threats	80	17
Accidents	103	22
Shock	122	26
Physical Abuse	152	32
Neglect	288	61
Death	215	46
Other	102	22

Abuse Specific Characteristics

- ✚ Males were more likely to report having to watch someone present their genitals, having to touch the genitals of others, having to masturbate while someone watched, oral and anal intercourse.
- ✚ Females were more likely to have been teased about sexual development, been kissed and fondled in a sexual way, touched in a sexual way (non-genital), and genital intercourse.
- ✚ The most common intrafamilial perpetrator was the father (30.9%), followed by siblings (15.8%), step-parent (15.1%), and mother (4.2%).
- ✚ Almost a third of the sample reported being abused by a non-family adult (32.7%) and 13.6% reported being abused by more than one person.
- ✚ Males were more likely to be abused by mothers and females were more likely to have been abused by their father and other family members.

Sexual abuse experiences are not mutually exclusive and often co-occur

Typologies of Childhood Sexual Abuse Experiences⁴

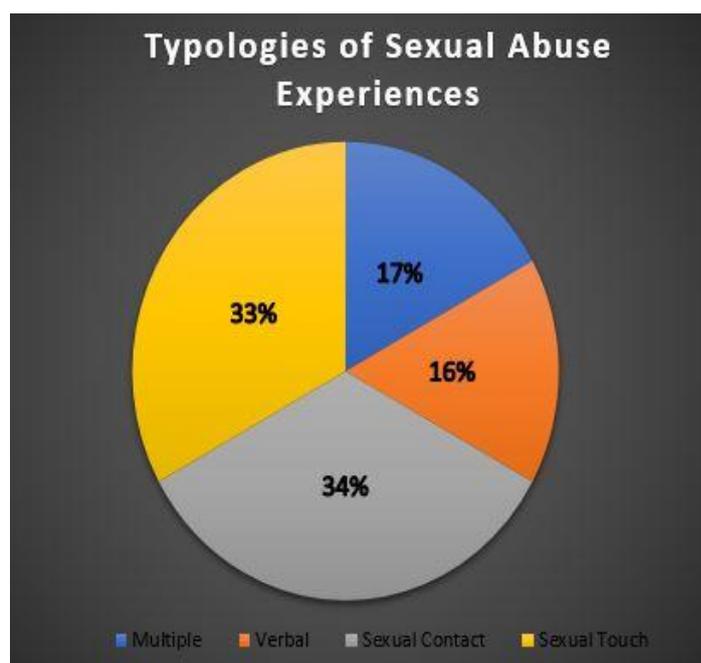
We conducted analyses to identify different typologies of sexual abuse experiences and found four groups:

- ✚ **Multiple Sexual Abuse** (N = 77, 17.0%) characterized by a relatively high probability of having experienced all the sexual abuse types.
- ✚ **Verbal Sexual Abuse** (N = 75, 16.5%) characterized by a relatively high

probability of having experienced verbal types of sexual abuse. Specifically, there was a high probability of having been spoken to about sexual matters, questioned about sexuality, teased about sexual development, and having had to listen to other's sexual experiences.

- ✚ **High Sexual Contact** (N = 154, 33.9%) characterized by a relatively high probability of having experienced sexual contact of a non-penetrative nature. In particular there was a high probability of having been kissed/fondled in a sexual way, watch adult intercourse or pornographic material, present own genitals to someone else, touched in a sexual way (non-genital), genitals were touched in a sexual way, and had to touch or fondle the genitals of someone else.
- ✚ **Sexual Touch** (N = 148, 32.6%) had the lowest rates of most sexual abuse types. The highest rates were characterised by; having to present own genitals to someone else, being touched in a sexual way (non-genital), genitals were touched in a sexual way, and having to touch or fondle the genitals of someone else.

Figure 2. Typologies of CSA Experiences



We then examined different sexual trauma variables to examine whether they differentiated between the 4 groups

- ✚ Frequency of abuse acts was significantly associated with the 'Sexual Touch' group with these individuals being more likely to be exposed to sexual abuse 2-3 times than at higher frequencies (e.g., 16-50 times and 51 or more times).
- ✚ Participants abused 51 or more times were grouped in the 'Multiple Sexual Abuse' class.
- ✚ Participants whose mothers were perpetrators were more likely to be grouped in the 'Verbal Sexual Abuse' group.
- ✚ Participants who experienced abuse by multiple perpetrators were associated with the 'Multiple Sexual Abuse' group.

Attachment and Dissociation⁵

We investigated the directionality of the relationship between attachment insecurities and dissociation over time during treatment to assess whether a change in attachment might act as a facilitating factor for integration and/or a decrease in dissociation during therapy.

- ✚ Results indicated that both attachment insecurities and dissociation reduced over time during treatment.
- ✚ Elevated attachment insecurities were associated with elevated dissociation at each of the measurements.
- ✚ A reciprocal association emerged between attachment avoidance and dissociation during treatment whereby low levels of attachment avoidance predicted a decline in dissociation and vice versa.

The present study has important implications for policymakers and therapists demonstrating that treatment of CSA survivors is effective and can lead to considerable improvement with regard to attachment and dissociation. Further, findings highlight the importance of assessing and addressing attachment insecurities, particularly avoidant attachment styles and dissociative experiences early in the therapeutic process as improvements in one domain leads to improvements in the other which will promote optimal treatment outcomes.

Predictors of Time Spent in Treatment⁶

Evidence suggests that therapeutic treatment for CSA can be effective, however, research demonstrates high rates of attrition. Premature treatment termination may decrease the positive effects of the treatment, leaving unresolved PTSD symptoms which in turn are associated with significantly impaired functioning and psychological distress.

Given the high treatment attrition rates within childhood trauma samples and the extant literature highlighting numerous problems associated with attrition, understanding factors relating to attrition rates would be beneficial in establishing the most efficacious treatment plans for CSA survivors.

In light of this research we aimed to identify factors which could predict length of time CSA survivors remained in treatment. Participants were categorised according to the length of time they spent in treatment (**T1**=0-6 months, **T2**=6-12 months, **T3**=12-18 months and **T4**=over 18 months) thus allowing for the comparison of participants who spent less than six months in treatment to participants who stayed in treatment for a longer period of time.

- ✚ Findings indicated childhood neglect and experiencing rape (lifetime) were found to be predictive for staying in treatment for less than six months.
- ✚ Being male and greater educational attainment were found to be associated with staying in treatment for longer.
- ✚ Contrary to previous research, we found no significant differences between time spent in treatment in relation to symptoms of PTSD, depression, anxiety, somatisation, sleeping problems, or dissociation.

These findings highlight that clinicians should be aware of the factors likely to predict time spent in treatment in order to identify individuals who may be at risk of dropping out at an early stage.

Posttraumatic Stress Disorder (PTSD)

PTSD is a common outcome after exposure to traumatic life events such as CSA which occurs more frequently in women than men.

Many theoretical models of PTSD indicate temporal ordering of symptoms during the acute traumatic response, although little consensus exists with regard to which symptoms are of primary importance. Understanding the course of symptom formation, variation, and temporal stability are essential for providing a comprehensive understanding of PTSD and for developing effective clinical interventions. Determining if a particular cluster of symptoms is dominant in the subsequent development of PTSD symptomology, and whether this varies over the course of the traumatic response, would allow clinicians to focus on the most critical symptoms depending upon when a patient presents for treatment.

We assessed the temporal relationships between the PTSD symptom clusters across three assessment periods (baseline, 6, and 12 months)⁷

- ✚ Results indicated cross-lagged effects were weak, with avoidance and emotional symptoms displayed the strongest cross-lagged effects followed by arousal symptoms and reexperiencing symptoms
- ✚ The auto-regression effects were of a much stronger magnitude than the cross-lagged effects.
- ✚ This suggests that decades after traumatic exposure, the symptom clusters of PTSD continue to influence one another, but only to a small degree. Each symptom cluster is best predicted by scores on the same variable at the previous assessment period.

We also examined individual PTSD clusters reexperiencing, arousal, and avoidance and emotional numbing scores at T1 as predictors of meeting caseness for PTSD 12 months later.

- ✚ The strongest odds ratios (OR) was observed for avoidance and emotional numbing followed by arousal and re-experiencing.

Our findings suggest that over the course of the traumatic response, temporal associations between the PTSD symptom clusters are relatively minor. Of the cross-lagged effects that are observable, avoidance and emotional numbing symptoms appear most relevant in the prediction of latter PTSD symptomology.

Examining Patterns of PTSD Treatment Response⁸

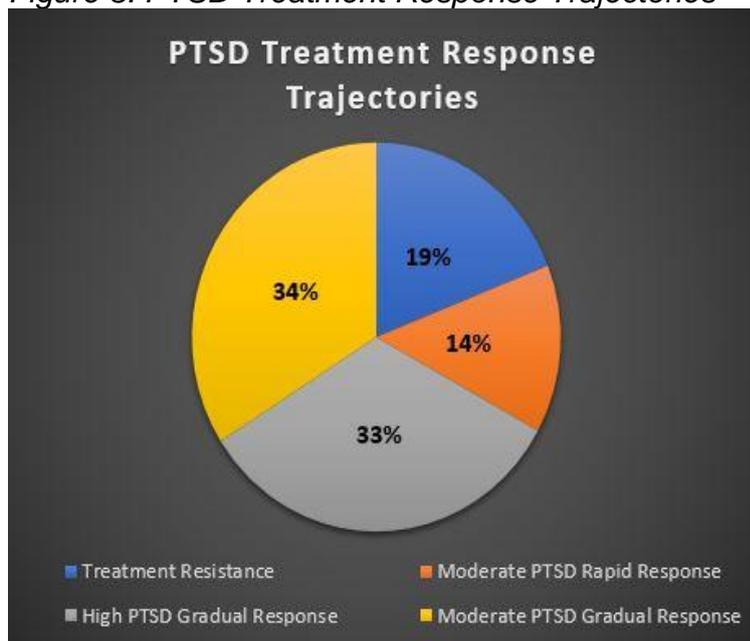
We then examined changes in PTSD over the course of treatment in order to provide a better understanding of treatment effectiveness using latent class growth models. Figure 3 shows that four subgroups emerged that were labelled.

- ✚ **High Treatment Resistant.** This comprised 19% of the sample and was characterised by low levels of change in PTSD across an 18-month period.
- ✚ **Moderate PTSD Rapid Responder.** This group consisted of 14% of the sample and findings indicated that there was a large reduction in PTSD levels over the 18-month period in particular during the first 6 months of treatment.
- ✚ **High PTSD Gradual Responder.** This group consisted of 33% of the sample had particularly high levels of baseline PTSD that gradually declined over the 18 months.
- ✚ **Moderate PTSD Gradual Responder.** This group consisted of 34% of the sample that showed consistent reductions in PTSD across 18 months

This study highlights that not all survivors respond to treatment in the same way. The emergence of different trajectories of PTSD recovery and in particular identifying a treatment resistant group that comprised of 18% of the sample has important treatment implications in PTSD recovery.

In order to develop a comprehensive risk profile for the different trajectories we then examined a number of factors that may place individuals into a high symptomatic and treatment resistant group in order to distinguish factors that may differentiate them from a treatment responsive trajectory.

Figure 3. PTSD Treatment Response Trajectories



Factors associated with Treatment Response Trajectories

- ✚ Higher levels of emotional coping were associated with the treatment resistant group compared to moderate PTSD groups
- ✚ Social support is protective against PTSD treatment resistance
- ✚ Social support between moderate PTSD response groups showing that higher social support was associated with better treatment outcome
- ✚ Treatment resistant group had higher levels of re-experiencing and avoidance PTSD symptoms compared to other PTSD treatment response groups

Adult Attachment and PTSD⁹

Insecure adult attachment manifests as attachment anxiety (the degree to which you trust someone for protection) and attachment avoidance (the degree of dependency and closeness you can tolerate). Individuals with low scores on both dimensions are considered securely attached and can effectively regulate affect when the attachment system is activated.

The effects of CSA on attachment insecurity therefore are particularly potent when the attachment figure is the perpetrator and leads to feelings of isolation. When applying this context to adult relationships it is likely insecurely attached individuals may be unable to turn to significant others for security, support and comfort, thereby making it difficult to regulate distress.

Delineating the impact CSA may have on adult attachment orientations and how individuals adapt and respond to such experiences is therefore instrumental in therapeutic settings.

Evidence suggests adult attachment theory can be usefully conceptualised within a framework for understanding affect regulation, resilience, and coping following childhood maltreatment however, there is a lack of research highlighting how attachment influences recovery over time.

Adult attachment is important in the therapeutic context to assess how survivors turn to significant others for security, support and comfort

- ✚ We found PTS levels and insecure attachment declined over the 12-months, insecure attachment orientations are significantly related to PTSD. Specifically, attachment avoidance exerted more influence on the maintenance of PTSD symptoms.

These findings have important implications as individuals with attachment avoidance use deactivating strategies that involve distancing themselves from negative emotions and other people which require targeted attention during the therapeutic process.

Dissociation and PTSD⁹

Dissociation can be conceptualised as a defence mechanism involving disengagement from the physical and emotional pain associated with the trauma exposure and includes symptoms such as depersonalisation, derealisation, amnesia and gaps in awareness.

The DSM-5 has included a dissociative-PTSD subtype which accounts for high levels of dissociative symptoms alongside PTSD. Research has found that those who experience dissociative-PTSD are more commonly exposed to complex forms of trauma, e.g. CSA.

- ✚ PTS and dissociative symptoms were strongly correlated at each assessment, in fact these correlations were stronger at 12-month assessment than they were at the baseline assessment.
- ✚ This indicates a very strong relationship emerged between PTS and dissociative symptoms decades after trauma exposure.
- ✚ These findings indicate that females who were continuing to report high levels of PTS and dissociative symptoms 6 to 12 months following treatment may represent the dissociative-PTSD group that has been recognised in the DSM-5.

These findings also support recent studies that have demonstrated dissociative-PTSD is more common in females who have experienced sexual trauma.

In another study we used individuals who met the threshold for a DSM-5 diagnosis of PTSD to examine whether different PTSD subtypes emerged.¹¹

Individuals with dissociative PTSD require specialized treatment

- ✚ The presence of two distinct classes emerged; a dissociative PTSD class (44.6%) and a non-dissociative PTSD class (55.4%).

- ✚ The dissociative PTSD class were found to have higher overall PTSD severity and used emotion focused coping styles.

These findings have important treatment implications as evidence suggests individuals who experience high levels of dissociation and PTSD respond better to phase-orientated treatment approaches. This type of treatment involves an initial focus on reducing symptom severity through skills training in emotion regulation followed by working through traumatic memory using techniques such as narrative storytelling.

DSM-5 versus ICD-11 PTSD¹²

The DSM-5 and ICD-11 have adopted two very different approaches to conceptualising PTSD with the former increasing the diagnostic criteria to 20 symptoms and the latter proposed to reduce the criteria to 6 symptoms.

The presence of two alternative methods of describing the same disorder presents a unique challenge to researchers and clinicians working with trauma-exposed individuals. Determination of the correct symptom profile for PTSD has implications in terms of prevalence of the disorder; for elucidating key etiological factors in the onset of the disorder; for refining treatment interventions that target the most important symptoms; and for facilitating the development of effective early interventions to prevent the onset of chronic PTSD.

We assessed if there was a meaningful difference in prevalence estimates using DSM-5 and proposed ICD-11 symptom profile of PTSD.

- ✚ Significantly more CSA survivors met caseness for PTSD according to DSM-5 versus the proposed ICD-11 model of PTSD (60.6% vs. 49.1%).
- ✚ Results suggested that the lower level of ICD-11 PTSD caseness was influenced by the selection of re-experiencing symptom indicators. Replacement of the 'recurrent nightmares' symptom with the 'recurrent thoughts/memories' symptom balanced the proportion of individuals meeting caseness for both taxonomies.

We also examined the associations of PTSD derived from both models with a range of psychiatric outcomes.

- ✚ Results indicated at both the subclinical and clinical severity thresholds outlined by the MCMI-III, there was a trend for the DSM- 5 PTSD symptom profile to yield higher levels of co-occurrence with the nine disorders.
- ✚ However, only in the case of anxiety and thought disorder did these differences reach the level of statistical significance.

- ✚ Notably, when the severe threshold was applied, co-occurrence with all disorders was extremely similar between the two symptom profiles.

These findings suggest that the selection of the ICD-11 or DSM-5 models of PTSD will have significant influence on the proportion of trauma-survivors who meet caseness for PTSD and the level of co-occurrence with other psychiatric disorders.

For clinicians and researchers, the discrepant phenotypic expression of PTSD presented by the two classification systems makes it challenging to identify agreed aetiological factors for the onset of PTSD. For example, evidence suggests that negative cognitions of the self are an important predictor in the development of subsequent PTSD symptomology. However, in the DSM-5 negative cognitions of the self are defined as a symptom of the disorder, not as an aetiological factor.

The difficulty in identifying agreed aetiological factors due to the alternative descriptions of the same disorder means that clinical interventions aimed at alleviating existing PTSD symptomology, as well as early interventions that aim to prevent the development of PTSD in those at risk for the disorder, is made extremely difficult.

Future research needs to determine the appropriate number and selection of symptom indicators for the ICD-11 model to measure the re-experiencing category, the effect such selection will have on the proportion of trauma-exposed individual who will reach diagnostic criteria, the observed comorbidity rates with other psychiatric disorders, and the effect such symptom selection will have on the overall validity of the proposed model.

Complex PTSD (CPTSD)¹³

The upcoming ICD-11 intends to propose the addition of CPTSD as a separate disorder. CPTSD manifests following prolonged and repeated traumatic events from which separation is not possible (e.g., CSA). CPTSD consists of the three core features of PTSD in addition to difficulties in affect dysregulation, self-concept and relational functioning, collectively described as disturbances in self-organisation (DSO).

CPTSD requires that in addition to the PTSD symptoms, an individual must display at least one symptom from each DSO domain. Affect dysregulation consists of a range of symptoms resulting from difficulties in emotion regulation which may manifest in heightened emotional reactivity or in a lack of emotions or dissociative symptoms. Self-concept difficulties refer to persistent negative beliefs about oneself, feelings of worthlessness, shame and guilt. Disturbances in relational functioning are characterised by difficulties in feeling emotionally close or engaging with others.

In examining the validity of the proposed ICD-11 criteria for Complex PTSD we found:

- ✚ 43% of the sample met the diagnostic criteria for CPTSD.
- ✚ Being female and experiencing a greater number of sexual abuse acts during childhood were more strongly associated with PTSD than CPTSD symptoms.
- ✚ Anxiety was more strongly associated with PTSD
- ✚ Dysthymia was more strongly associated with CPTSD.

These findings provide considerable support for the proposition that exposure to childhood trauma increases the likelihood of a CPTSD diagnosis in adulthood, in addition to PTSD diagnosis. This result should highlight to both researchers and clinicians the importance of screening for CPTSD when working with individuals who were exposed to trauma during their early development. The recognition of a unique CPTSD disorder may require alternative clinical interventions to the standard evidence-based methods of treating PTSD.

Conclusions

- ✚ This collection of studies are based on data that have followed a large sample of help-seeking survivors of CSA over four assessment periods, addressing some of the limitations of previous work.
- ✚ Findings have revealed that comorbid disorders are common, which has important implications for the continued investment into these centres to provide intensive treatment to adult survivors of CSA.
- ✚ Findings also provide valuable information on how PTSD prevalence rates can vary depending on which classification system is used (DSM-IV, DSM-5 and the proposed ICD-11)^{2,11,12}
- ✚ Findings highlight the importance of addressing attachment insecurities (particularly avoidant attachment) and dissociative symptoms at early stages of the therapeutic process
- ✚ Given the significant time period (average 23 years post abuse onset) raises several questions regarding process of disclosure of CSA and seeking treatment. We recommend that more research attention centres around the disclosure process, disclosure to different sources (e.g., law enforcements, criminal justice system, health professionals, family members, or friends) and the level of public awareness of seeking help for CSA.
- ✚ This latter point in particular should be a targeted area of focus as the way in which a multidisciplinary system interacts with CSA survivors going public can have implications for the recovery process and prevent secondary

traumatisation whereby negative interactions with service providers can lead to additional trauma for the survivor.

- ✚ Based on our findings the most significant reductions in traumatic symptomatology occurred during the first 6 months of therapy therefore future research into the timing of interventions/therapy is crucial for more in-depth understanding of the recovery process. Notably, as the effects of continued therapy in the post 6-month period have also been demonstrated we are currently waiting on additional data for a more thorough examination of longer terms treatment effectiveness.
- ✚ Our findings further highlight the importance of clinicians and practitioners being well trained in assessing a range of outcomes and disentangling the prominent problem areas for focus in the therapeutic process.
- ✚ Our findings underscore the need for investment in the development of appropriate local services and treatment centres to meet the needs of survivors of CSA

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Forthcoming Studies

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| RÅDET FOR OFFERFONDEN |

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