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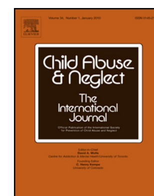

Posttraumatic symptom profiles among adult survivors of childhood sexual abuse: A longitudinal study

Iris M. Steine[a,b,*], Dagfinn Winje[a], Jens Christoffer Skogen[c], John H. Krystal[d,e], Anne Marita Milde[f,g], Bjørn Bjorvatn[h,i], Inger Hilde Nordhus[a,j], Janne Grønli[g,k], Ståle Pallesen[i,l]

[a] Department of Clinical Psychology, University of Bergen, Christiesgate 12, 5015 Bergen, Norway
[b] Visiting Scholar, UC Berkeley, Department of Psychology, 4123 Tolman Hall, Berkeley, CA 94720-1690, USA
[c] Department of Public Mental Health, Division of Mental Health, Norwegian Institute of Public Health, Christiesgate 13, 5020 Bergen, Norway
[d] Clinical Neuroscience Division, VA National Center for PTSD, 950 Campbell Avenue West Haven, CT 06516, USA
[e] Department of Psychiatry, Yale University School of Medicine, 300 George Street, Suite 901, New Haven, CT 06511 USA
[f] Regional Centre for Child and Youth Mental Health and Child Welfare, Postbox 7810, 5020 Bergen, Norway
[g] Department of Biological and Medical Psychology, University of Bergen, Jonas Lies vei 91, 5009 Bergen, Norway
[h] Department of Global Public Health and Primary Health Care, University of Bergen, Kalfarveien 31, 5018 Bergen, Norway
[i] Norwegian Competence Center of Sleep Disorders, Haukeland University Hospital, PO Box 1400, 5021 Bergen, Norway
[j] Institute of Basic Medical Sciences, University of Oslo, PO Box 1110 Blindern 0317 Oslo, Norway
[k] Washington State University, PO BOX 1495 Spokane, WA 99210-1495, USA
[l] Department of Psychosocial Science, University of Bergen, Christiesgate 12, 5015 Bergen, Norway

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ABSTRACT

In the present study, our aim was to examine longitudinal posttraumatic stress symptom (PTSS) trajectories in a Norwegian sample of adults who had experienced sexual abuse during childhood, and to identify predictors of PTSS-trajectory belongingness. The sample consisted of 138 adult survivors of childhood sexual abuse (96.4% women, mean age = 42.9 years, mean age at the first abuse = 5.9 years), recruited from support centers for sexual abuse survivors. The majority (78.3%) reported penetrative abuse, and a large proportion of the sample reported that the perpetrator was a biological parent (38.4%) or someone they trusted (76.1%), reflecting a high severity level of the abusive experiences. Latent Profile Analyses revealed the best overall fit for a two PTSS-trajectories model; one trajectory characterized by sub-clinical and decreasing level of PTSS (54.9%), and the other by high and slightly decreasing level of PTSS (45.1%). Increased odds for belonging to the trajectory with clinical level symptoms was found among those who reported higher levels of exposure to other types of childhood maltreatment (OR = 3.69, $p = 0.002$), sexual abuse enforced by physical violence (OR = 3.04, $p = 0.003$) or threats (OR = 2.56, $p = 0.014$), very painful sexual abuse (OR = 2.73, $p = 0.007$), or who had experienced intense anxiety, helplessness or fear during the abuse (OR = 2.97, $p = 0.044$). Those in the trajectory with clinical level PTSS reported lower levels of perceived social support and more relational difficulties compared to those in the sub-clinical PTSS trajectory. In conclusion, different longitudinal PTSS trajectories can be found among adult survivors of childhood sexual abuse. Significant predictors of PTSS-trajectory belongingness are discussed alongside their potential implications for preventive efforts and clinical interventions.

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* Corresponding author at: University of Bergen, Department of Clinical Psychology, Christiesgate 12, 5015 Bergen, Norway.
E-mail addresses: iris.steine@uib.no, iris.steine@gmail.com (I.M. Steine).

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1. Introduction

Childhood sexual abuse occurs at alarming rates worldwide, with prevalence rates ranging between 8 and 31% for women and 3–17% for men (Barth, Bermetz, Heim, Trelle, & Tonia, 2013; Finkelhor, 1994; Pereda, Guilera, Forns, & Gómez-Benito, 2009a, 2009b; Stoltenborgh, van Ijzendoorn, Euser, & Bakermans-Kranenburg, 2011). In Norwegian representative population studies, the prevalence of unwanted sexual intercourse among women has been reported to be 11.4% before age 16 (the age of consent to sexual activity in Norway) (Steine et al., 2012), while the prevalence of a broader spectrum of unwanted sexual contact has been found to be 18.3% before age 16, and 21.2% before age 18 (the age that defines the end of childhood, according to the United Nations Convention on the Rights of the Child) (Steine et al., 2012; Thoresen & Hjemdal, 2014). The burden of sexual abuse for those victimized is evident from a massive body of literature linking childhood sexual abuse to altered neurobiology and stress physiology (Andersen et al., 2008; Bremner et al., 1997; Hulme, 2011; Stein, Koverola, Hanna, Torchia, & McClarty, 1997; Vythilingam et al., 2002), increased stress-sensitivity later in life (Kendler, Kuhn, & Prescott, 2004), life-long increased risk of multiple mental and somatic disorders and health problems (Beichtman, Zucker, Hood, DaCosta, & Akman, 1991; Chen et al., 2010; Fergusson, McLeod, & Horwood, 2013; Finkelhor, 1990; Jumper, 1995; Kendall-Tackett, Williams, & Finkelhor, 1993; Maniglio, 2009; Paras et al., 2009), as well as death by suicide (Cutajar et al., 2010; Ford & Gomez, 2015; Plunkett et al., 2001). In addition to the immense human costs, childhood sexual abuse is associated with significant societal economic costs in the form of increased health care utilization among those victimized (Hulme, 2000; Walker, Unutzer et al., 1999).

Posttraumatic stress symptoms (PTSS) are characterized by re-experiencing the trauma, avoidance of trauma-related stimuli, and negative alterations of cognition, mood, arousal and reactivity following exposure to a stressor (American Psychiatric Association, 2013). PTSS are among the most frequently reported symptoms among childhood sexual abuse survivors (Chen et al., 2010; Fergusson et al., 2013; Kendall-Tackett et al., 1993; Paolucci, Genius, & Violato, 2001). However, in line with findings from studies of posttraumatic stress following other adverse events (de Jong et al., 2001; Harvey & Bryant, 1998; Xue et al., 2015), not all sexually abused individuals develop these symptoms (Kendall-Tackett et al., 1993; Paolucci et al., 2001). Several meta-analyses have examined predictors of posttraumatic symptomatology in order to identify risk and protective factors. However, the majority of these studies have been conducted in samples of combat veterans or victims of other trauma types (e.g. natural disasters, crime, accidents), whereas samples of sexual abuse survivors have been scarce (Brewin, Andrews, & Valentine, 2000; Ozer, Best, Lipsey, & Weiss, 2008). Although some risk factors have been found to reliably predict posttraumatic stress disorder (PTSD)-symptom severity across different trauma populations (e.g. previous history of childhood abuse or other adversities); other risk factors (e.g. age at trauma) show heterogeneous effects for different trauma types, suggesting that a general risk-factor model across different trauma populations is not justified (Brewin et al., 2000). This highlights the need for studies examining risk and protective factors in sexually abused samples specifically.

Of the previously conducted studies in sexually abused samples, some have reported statistical correlates of PTSS cross-sectionally among children and adolescents. Hébert and colleagues found that repeated sexual abuse and lower levels of perceived maternal or peer support were associated with increased risk of reaching clinical levels of PTSS among 694 sexually abused individuals from a representative sample of 8194 high school students (Hébert, Lavoie, Blais, & team, 2014). In a sample of 90 children reported to authorities due to sexual abuse, Wolfe and colleagues found that abuse involving threats and force by the perpetrator, and abuse of longer duration, was associated with increased risk of fulfilling diagnostic criteria of PTSD, and that a close relationship to the perpetrator was associated with higher posttraumatic symptom scores (Wolfe, Sas, & Wekerle, 1994).

In addition to these cross-sectional studies, a few studies have examined posttraumatic symptoms longitudinally among adolescents or adults with childhood sexual abuse histories. In a follow-up study of 100 adolescents who had recently disclosed sexual abuse, Bal, De Bourdeaudhuij, Crombez, and Van Oost (2005) found that lack of crisis support following the abuse was associated with more symptoms, including posttraumatic stress, six months later, whereas the type or severity of the abuse did not account for differences in symptomatology (Bal et al., 2005). Trickett, Noll, and Putnam (2011) found higher PTSS scores among sexually abused compared to non-abused women in a 23-year longitudinal study of 84 women who had experienced intrafamily sexual abuse. However, they did not report on predictors for levels of PTSS specifically (Trickett et al., 2011). In a sample of 987 women and men from the Christchurch Health and Development Study birth cohort, Fergusson and colleagues found that sexual abuse before the age of 16 years was associated with higher levels of PTSS at age 30 years compared to those without sexual abuse histories, and that those who had experienced penetrative abuse had the highest PTSS scores (Fergusson et al., 2013).

1.1. Posttraumatic symptom trajectories

All of the abovementioned studies reported PTSS outcomes for the study samples as a whole, without exploring whether different symptom severity sub-groups could be identified. While these studies are effective in showing that childhood sexual abuse increases the life-long risk for PTSS, they reveal little about potential heterogeneity in symptom trajectories. More knowledge on different PTSS severity sub-groups and predictors of sub-groups in sexually abused samples is of both theoretical and practical importance, as it may advance our understanding of differences in posttraumatic stress symptomatology in this group. Such knowledge may for instance aid identification of sub-groups of individuals who are at higher

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