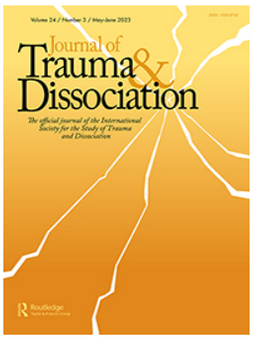

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Posttraumatic Growth, Dissociation and Identification With The Aggressor Among Childhood Abuse Survivors

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ABSTRACT

Childhood abuse puts individuals at risk for psychopathology and psychiatric symptoms such as posttraumatic stress disorder (PTSD) and anxiety symptoms. At the same time, research has indicated that some survivors report positive transformations in the aftermath of their trauma, known as posttraumatic growth (PTG). Yet the essence of PTG reports is questionable, and some scholars claim that it may reflect maladaptive illusory qualities. Furthermore, according to a recent theoretical model, PTG might be dissociation-based and related to survivors' bonds with their perpetrators. This study aimed to explore these claims by assessing PTG, dissociation, and identification with the aggressor (IWA), as well as PTSD and anxiety symptoms. An online survey was conducted among 597 adult childhood abuse survivors. Study variables were assessed via self-report measures. Analyses indicated positive associations between PTG, dissociation, and IWA. Three distinct profiles were found, reflecting high, medium, and low scores on PTG, dissociation, and IWA. Profile type explained PTSD and anxiety symptoms above and beyond gender, age, and abuse severity. These findings suggest that whereas some childhood abuse survivors might experience a positive transformation subsequent to their trauma, others' PTG reports might reflect dissociative mechanisms and pathological attachments to their perpetrators, and thus might be maladaptive.

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Childhood abuse; posttraumatic growth; dissociation; identification with the aggressor; trauma

Introduction

Childhood abuse is a pervasive, global problem that substantially hampers the well-being of millions of children around the world (Stoltenborgh et al., 2015). The long-term ramifications of childhood abuse are multifaceted and include posttraumatic stress disorder (PTSD), anxiety, dissociation, substance use disorders, eating disorders, non-suicidal self-injury, sexual dysfunction, poor physical health, and depression (Ford & Gómez, 2015; Gewirtz-Meydan & Lahav, 2020a, 2020b; Lindert et al., 2014; Messman-Moore & Bhuptani, 2017; Nelson et al., 2017; Vonderlin et al., 2018; Wegman & Stetler, 2009).

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Despite these detriments, salutogenic effects resulting in positive transformations, often known as posttraumatic growth (Tedeschi & Calhoun, 1996), have also been found among childhood abuse survivors. Posttraumatic growth is defined as positive changes subsequent to trauma exposure which go beyond pre-trauma adjustment and which are displayed in an enhanced appreciation of life, changes in priorities, more meaningful relationships with others, a sense of increased personal strength, new possibilities for the future, and existential/spiritual thriving (Tedeschi & Calhoun, 1996; Tedeschi et al., 2018). Research has documented reports of PTG among survivors of various types of traumatic events (Brooks et al., 2020; Levi-Belz et al., 2020; Mark et al., 2018; Stein et al., 2020), among them childhood abuse (Easton et al., 2013; Kaye-Tzadok & Davidson-Arad, 2016; Lahav, Ginzburg, et al., 2020; Lev-Wiesel et al., 2004; Mohr & Rosén, 2017; Schaefer et al., 2018; Shakespeare-Finch & De Dassel, 2009; Woodward & Joseph, 2003).

Nevertheless, a deeper look at the clinical and empirical literature indicates that the very nature of PTG reports is debatable. Specifically, it is unclear whether reports of PTG reflect positive transformations resulting from struggles with trauma (Calhoun & Tedeschi, 2014; Tedeschi et al., 2018), or encompass illusory aspects that may negatively affect survivors' adjustment (Davis & McKearney, 2003; Hobfoll et al., 2007; Maercker & Zoellner, 2004; McFarland & Alvaro, 2000). A recent theoretical model which extends the latter view suggests that dissociation, defined as a disruption in the integration of mental processes (American Psychiatric Association, 2013), might be involved in trauma survivors' reports of growth (Lahav, Bellin, et al., 2016). That is, although some survivors might experience positive transformations, other survivors' reports of PTG may stem from dissociative mechanisms that are aimed to block out traumatic material and reflect the formation of a maladaptive disintegrated belief system (Lahav, Bellin, et al., 2016). Furthermore, under conditions of recurrent "relational" abuse, such as childhood abuse, these dissociation-based beliefs of PTG might be associated with the unique bonds often formed between victims and their perpetrators, known as *identification with the aggressor* (Lahav, Talmon, & Ginzburg, 2019).

Identification with the aggressor, a concept which was originally developed by (Ferenczi, 1932, 1933), is a mechanism that aims to promote abuse victims' survival by their fusing with, taking on, and introjecting their perpetrators' experience. Although this defensive reaction has an interpersonal function, as it enables the victim to preserve a positive relationship with the perpetrator, it is not limited to childhood abuse inflicted by a parental figure (Lahav, 2021a, 2022; Lahav, Talmon, & Ginzburg, 2019). In fact, IWA may develop as a result of power asymmetry between the victim and perpetrator, when the victim cannot escape, avoid, or prevent the attacks (Frankel, 2002).

The person's (dissociated) self-states that identify with the aggressor lose their own agency and connection to their own wants and needs, become

submissive, and undergo mental fusion with the perpetrators via an adoption of the perpetrators' point of view concerning the abuse (Amir, 2016; Coates & Moore, 1997; Lahav, Allende, et al., 2020; Lahav, Talmon, & Ginzburg, 2019; Lahav, et al., 2019). Although this type of identification is assumed to be an automatic reaction that has advantageous effects in terms of promoting survival during the abuse (Frankel, 2002), it often becomes entrenched in victims' mentality and continues to exist long after the abuse has ended (Lahav, 2021b; Lahav, Talmon, & Ginzburg, 2019). Thus, adult survivors of childhood abuse might view their traumatic past from their perpetrators' perspectives and not only deny and minimize the abuse, but also attribute to it beneficial aspects as reflected in reports of PTG (Lahav, Seligman, et al., 2017). Similar to other byproducts of dissociation, these dissociation-based PTG beliefs may provide emotional relief in the short term, but preclude survivors from re-processing their traumatic past, thus exacerbating their distress.

Research has provided some support for these claims. A previous study among former prisoners of war indicated that reports of PTG were associated with elevated dissociation and negative beliefs regarding the self and the world, thus suggesting that these reports were part of a disintegrated dissociative belief system rather than the result of efforts to work through the trauma (Lahav, Bellin, et al., 2016). A longitudinal study among Israeli civilians exposed to rocket fire revealed that acute dissociative reactivity predicted reports of elevated PTG levels two months later (Greene, 2018). Lastly, a study among adult survivors of childhood sexual abuse who participated in a 6-month efficacy trial implied that PTG reports among some survivors might mirror dissociation-based beliefs that could be maladaptive. Specifically, findings indicated that dissociation moderated the relations between PTG and subsequent sexual revictimization: Whereas PTG had non-significant effects on revictimization in survivors with low dissociation, it predicted elevated levels of revictimization in survivors with high dissociation (Lahav, Ginzburg, et al., 2020).

Nevertheless, to the best of our knowledge, the relation between PTG reports on the one hand and dissociation and IWA on the other have yet to be investigated. Furthermore, there has been no empirical investigation aiming to uncover discrete patterns concerning PTG, dissociation, and IWA among childhood abuse survivors, and their relation to survivors' distress. According to the theoretical model proposed by Lahav et al., (Lahav, Bellin, et al., 2016; Lahav, Seligman, et al., 2017), different patterns concerning PTG, dissociation, and IWA among abuse survivors might reflect distinct types of PTG consisting of authentic growth (resulting from struggling with the trauma) versus dissociation-based PTG beliefs that are related to the adoption of the perpetrator's perspective. Whereas the former is expected to have beneficial effects on adjustment, the latter is argued to be maladaptive and to exacerbate survivors' psychopathology.

Addressing this void, the present study set three main goals. The first was to explore the relation between PTG on the one hand, and dissociation and IWA, on the other. The second was to identify different profiles of PTG, dissociation, and IWA and their prevalence among childhood abuse survivors. The third was to assess the contribution of profile type of PTG, dissociation, and IWA in explaining PTSD and anxiety symptoms among this cohort. Based on the theoretical perspective suggested by Lahav et al., (Lahav, Bellin, et al., 2016; Lahav, Seligman, et al., 2017), it was hypothesized that PTG reports would be related to dissociation and IWA, and that different profiles of PTG, dissociation, and IWA would explain PTSD and anxiety symptoms among childhood abuse survivors: Survivors characterized by elevated levels of PTG, dissociation, and IWA would suffer from elevated levels of PTSD and anxiety symptoms compared to survivors who exhibited lower levels of PTG, dissociation, and IWA.

Methods

Participants and procedure

An online survey was conducted among a convenience sample of Israeli adults. A secure web-based survey data collection system was published on social media and accessible through Qualtrics. The survey was advertised as a study exploring the implications of adverse life events and took an average of 25 minutes to complete, and was open from October 4, 2019 to October 22, 2019. The survey was anonymous, and no data were collected that linked participants to recruitment sources. The Tel Aviv University institutional review board (IRB) approved all procedures and instruments. Clicking on the link to the survey guided potential respondents to a page that provided information about the purpose of the study, the nature of the questions, and a consent form. The first page also included researcher contact information. Each participant was given the opportunity to take part in a lottery that included four $60 gift vouchers.

A total of 1,081 people responded to the survey. Of them, only participants who were classified as having a history of childhood abuse based on the short form of Childhood Trauma Questionnaire (CTQ-SF; Bernstein et al., 2003) were included in the study. Participants were classified as having a history of abuse if they had scores that were higher than the cutoff scores suggested by (Tietjen et al., 2010): physical abuse > = 8; sexual abuse > = 6; and emotional abuse > = 9.

Of the total, 737 participants were classified as having a history of abuse, and 597 who provided data regarding the present variables were included in the current analyses. Of them, 238 (39.9%) were classified as having a history of childhood physical abuse; 375 (62.8%) were classified as having a history of

childhood sexual abuse; and 487 (81.6%) were classified as having a history of childhood emotional abuse. Thus, the majority of the sample ($n = 347$, 58.1%) was classified as having a history of at least two types of abuse.

Participants' ages ranged from 18–70 ($M = 28.32$, $SD = 10.40$). The majority of the sample were women ($n = 481$, 80.6%), secular ($n = 420$, 70.4%) with some level of higher education ($n = 328$, 54.9%). Of the total sample, 353 (59.1%) reported having a below-average income, and most indicated that they were not in a relationship ($n = 352$, 59.0%). Most reported being abused by non-parental figures ($n = 430$, 72.0%). The average age when the abuse began was 11.69 ($SD = 6.54$) years; the average abuse severity, as reflected by the CTQ-SF total score, was 53.57 ($SD = 18.01$.

Measures

Background variables

Participants completed a brief demographic questionnaire that assessed age, education, and relational status.

Posttraumatic growth

Posttraumatic growth attributed to childhood abuse was assessed via the Post Traumatic Growth Inventory (Tedeschi & Calhoun, 1996). For each of the 21 statements in the questionnaire, participants were asked to rate the extent to which the indicated change occurred in their lives as a result of their childhood trauma. Each item was scored on a 4-point scale ranging from 1 (*I didn't experience this change at all*) to 4 (*I experienced this change to a very great degree*). The total score was computed according to five subscales: relating to others, new possibilities, personal strength, spiritual change, and appreciation of life. The PTGI has shown good internal consistency, construct, convergent, and discriminant validities (Tedeschi & Calhoun, 1996). Apart from the spiritual change subscale, internal consistency reliabilities were good ($\alpha =$ 0.86, 0.86, 0.85, 0.56, 0.75, 0.94, for relating to others, new possibilities, personal strength, spiritual change, appreciation of life, and total score, respectively).

The identification with the aggressor scale

Identification with the aggressor was assessed via the IAS, a 23-item self-report questionnaire (Lahav, Talmon, & Ginzburg, 2019). The items were presented to the respondents as reflecting "possible reactions that people may experience as a result of abuse." Participants were asked to rate on an 11-point Likert-type scale, ranging from 0% (*never*) to 100% (*all the time*), the frequency with which they experienced each manifestation of IWA in regard to their perpetrator.

The scale comprises four subscales: adopting the perpetrator's experience concerning the abuse (9 items; e.g., "Some people feel that the point of view of

their perpetrator is the right one"), identifying with the perpetrator's aggression (5 items; e.g., "Some people feel that they behave as aggressively as their perpetrator"), replacing one's agency with that of the perpetrator (5 items; e.g., "Some people do not know what they want in the presence of their perpetrator"), and becoming hypersensitive to the perpetrator (4 items; e.g., "Some people 'read the thoughts' of their perpetrator"). For the purpose of this study, we used the IAS total score, which was calculated by averaging all 23 items. The IAS has been shown to have good psychometric properties, including high construct and criterion validity, as well as high internal reliability (Lahav, Talmon, & Ginzburg, 2019). In this study, the internal consistency was high: 0.93 for the total score.

Dissociation

Dissociation was measured by the Dissociative Experiences Scale-II (DES-II; Bernstein & Putnam, 1986), a 28-item self-report questionnaire that measures the frequency of dissociative experiences. The total dissociative score was computed as the mean of these 28 items, ranging from 0 to 100. The DES-II has been shown to have high validity and reliability (Frueh et al., 1996). In the present study, the inventory was found to have high internal consistency ($\alpha = 0.95$).

PTSD symptoms

PTSD symptoms were measured via the PTSD Checklist for DSM-5 (PCL-5; Weathers et al., 2013). This 20-item self-report asks participants to indicate the extent to which they experienced each PTSD symptom, on a 5-point Likert-type scale ranging from 0 (*not at all*) to 4 (*extremely*). Items correspond to the PTSD symptom criteria in the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2013). A total score of PTSD symptoms was calculated by summing all 20 items. The PCL-5 demonstrates high internal consistency and test-retest reliability (Bovin et al., 2016). In this study the internal consistency reliability for the total score was excellent ($\alpha = 0.95$).

Anxiety symptoms

Levels of anxiety symptoms were assessed by the anxiety subscale of the Brief Symptom Inventory-18 (BSI-18; Derogatis, 2001) which consists of six items. Participants were asked to indicate the extent to which they had been bothered by the symptom in the prior week, on a 5-point Likert scale ranging from 0 (*not at all*) to 4 (*extremely*). The BSI-18 has been found to have adequate convergent and discriminant validity and good reliability (Derogatis, 2001). Internal consistency reliability in this study was excellent ($\alpha = 0.89$).

Covariates

Participants' gender, age, and childhood abuse severity, as reflected in the total score of the CTQ-SF (Bernstein et al., 2003), were significantly related to anxiety and PTSD symptoms (P_s<.01). Thus, all three variables were adjusted for in the present analyses.

Analytic strategy

To explore the relation between PTG, IWA, and dissociation, Pearson correlation analyses were conducted. A latent profile analysis (LPA) was conducted to derive discrete latent variables that describe distinct subgroups of participants who share similar patterns of PTG, IWA, and dissociation. The best fitting model was determined by an analytic hierarchy process that makes use of Akaike's Information Criterion (AIC), Approximate Weight of Evidence (AWE), Bayesian Information Criterion (BIC), Classification Likelihood Criterion (CLC), and Kullback Information Criterion (Akogul & Erisoglu, 2017). Next, two ANCOVAs were used to examine the contribution of latent class membership derived from the LPA in explaining PTSD and anxiety symptoms. Age, gender, and abuse severity were entered as covariates.

Results

PTG, dissociation, and IWA

As can be seen in Table 1, there were significant yet weak relations between PTG scores, dissociation and IWA: The higher the PTG scores, the higher the levels of dissociation and IWA.

Profiles of PTG, dissociation, and IWA

Results from the analytic hierarchy process indicated that the best fitting model was a 3-class model with uniquely estimated variances across profiles and covariances fixed to 0 (see Table 2). Profile 1 (n = 209; 35.0% of the entire sample) was characterized by relatively high levels of PTG, dissociation, and IWA (M = 2.44, SD = 0.74; M = 45.23, SD = 15.64; M = 52.55, SD = 19.29, respectively). Profile 2 (n = 302; 50.6% of the entire sample) was characterized by relatively moderate levels of PTG, dissociation, and IWA (M = 2.39, SD = 0.69; M = 16.77, SD = 8.72; M = 30.26, SD = 14.81, respectively). Profile 3 (n = 83; 14.4% of entire sample) was characterized by relatively low levels of PTG, dissociation, and IWA (M = 1.31, SD = 0.27; M = 8.37, SD = 4.68; M = 16.68, SD = 10.47, respectively).

Table 1. Inter-correlations among the study variables (n = 597).

Measure	1	2	3	4	5	6	7	8	9	10
1. PTG - relating to others	-									
2. PTG - new possibilities	.72***	-								
3. PTG - personal strength	.64***	.69***	-							
4. PTG - spiritual change	.50***	.50***	.48***	-						
5. PTG - appreciation of life	.65***	.68***	.65***	.48***	-					
6. PTG - total score	.90***	.89***	.85***	.64***	.82***	-				
7. Dissociation	.13**	.20***	.10*	.16***	.14**	.17***				
8. IWA	.17***	.21***	.10*	.08*	.15***	.18***	.46***	-		
9. PTSD symptoms	.24***	.29***	.18***	.23***	.22***	.28***	.44***	.35***	-	
10. Anxiety symptoms	.19***	.19***	.14***	.16***	.18***	.21***	.45***	.35***	.65***	-
1.58	34.10	36.10	25.52	2.25	2.32	2.19	2.59	2.18	2.19	M
1.12	19.84	20.56	18.56	.76	.97	.82	.93	.92	.82	(SD)

IWA = Identification with the aggressor. *$p < .05$; **$p < .01$; ***$p < .001$.

Table 2. Latent profile analysis fit indices.

Model Number	Classes	AIC	BIC	Entropy
1	1	5091.64	5117.99	1.00
1	2	4871.16	4915.08	0.81
1	3	4811.50	4872.99	0.77
2	1	4929.45	4968.98	1.00
2	2	4900.55	4957.65	0.63
2	3	4810.17	4884.83	0.66
3	1	5091.64	5117.99	1.00
3	2	4791.92	4849.02	0.64
3	3	4726.18	4814.02	0.67
4	1	4929.45	4968.98	1.00
4	2	4785.80	4869.25	0.64
4	3	4713.45	4840.81	0.67

AIC = Akaike information criterion, BIC = Bayesian information criterion. Lower AIC, BIC values indicate a better fitting model. Entropy values approaching 1 indicate high classification probabilities.

Table 3. Estimates for the three prototypical profiles and means and standard deviations of PTSD symptoms and anxiety symptoms ($n = 597$).

PTSD symptoms			Anxiety symptoms			
Group comparisons	*F*	η^2_p	Group comparisons	*F*	η^2_p	
Profile type	42.18*** (2, 591)	.13	a>b>c	46.31*** (2, 591)	.14	a>b>c
Gender	16.91*** (1, 591)	.03		17.66*** (1, 591)	.03	
Age	16.18***(1, 591)	.03		2.68 (1, 591)	.01	
Abuse severity	84.68***(1, 591)	.13		41.16***(1, 591)	.07	

** $p < .01$; *** $p < .001$.*Note*. The group comparisons column compares the mean level of the variable in each group: a = profile 1; b= profile 2; c= profile 3.

Profile membership and PTSD and anxiety symptoms

Two ANCOVAs were conducted to assess the contribution of profile in explaining PTSD and anxiety symptoms, above and beyond gender, age, and abuse severity. Table 3 presents the results, showing that profile type had significant effects for PTSD and anxiety symptoms. Participants in Profile 1 (high PTG, dissociation, and IWA) had the highest scores on PTSD and anxiety symptoms, $M = 44.43$, $SD = 19.70$; $M = 2.20$, $SD = 1.11$, respectively, following participants in Profile 2 (medium levels of PTG, dissociation, and IWA), $M = 31.41$, $SD = 17.01$; $M = 1.37$, $SD = 0.99$, respectively, following participants in Profile 3 (low levels of PTG, dissociation, and IWA), $M = 18.52$, $SD = 15.93$; $M = 0.83$, $SD = 0.79$, respectively.

Discussion

This study aimed to investigate for the first time the relation between PTG on the one hand and dissociation and IWA on the other, among childhood abuse survivors. The results revealed significant associations between PTG, dissociation, and IWA, and three distinct profiles (of these constructs) which were found to explain survivors' PTSD and anxiety symptoms.

Positive associations were found between PTG, dissociation and IWA: The higher the levels of PTG, the higher the levels of dissociation and IWA. Several explanations might be offered for the present findings. According to Calhoun & Tedeschi (Calhoun & Tedeschi, 2014), individuals who experience a positive transformation subsequent to their trauma develop more complex self-conceptions. Thus childhood abuse survivors who report PTG might be more capable of acknowledging their struggles as indicated in elevated dissociation and IWA. That said, according to this theoretical model these complex views of self are assumed to be integrated (Calhoun & Tedeschi, 2014). Yet integration is the very process that is disrupted via dissociative mechanisms (American Psychiatric Association, 2013). Hence, although this explanation cannot be ruled out, its likelihood is questionable.

Alternatively, it might be that childhood abuse survivors' reports of PTG reflect efforts to rely on positive appraisals as a way to cope with their current difficulties. Childhood abuse survivors who suffer from elevated dissociation and pathological attachment to their perpetrators might attribute to their past abuse beneficial effects, in order to better handle their current plight. Previous evidence suggesting that views regarding personal enhancement might be illusory and reflect efforts to cope with threatening events (McFarland & Alvaro, 2000) provide some support for this explanation.

Lastly, the positive relation between PTG, dissociation, and IWA may reflect the involvement of dissociative mechanisms in some reports of PTG, and their link to the affiliated bonds between victims and their perpetrators (Lahav, Bellin, et al., 2016; Lahav, Seligman, et al., 2017). Children who are subjected to emotional, physical, or sexual abuse undergo a betrayal at the hands of those who are meant to protect them and upon whom they are dependent (Freyd, 1996). Resisting the perpetrator is therefore counterproductive and dangerous (Freyd, 1996). Instead, mechanisms that enable abused children to block out emotional pain and bond with their perpetrators are automatically activated (Frankel, 2002, 2018), leading to the formation of a dissociated disintegrated belief system: Negative views which are linked to traumatic material and emotions such as fear, anger, and repulsion exist in a disconnected manner alongside beliefs regarding the benefits of the abuse, which mirror the perpetrator's perspective (Lahav, Bellin, et al., 2016; Lahav, Seligman, et al., 2017). The latter might be manifested in reports of PTG that continue to exist long after the abuse has ended.

Understanding reports of PTG in light of dissociation (Lahav, Bellin, et al., 2016), might clarify the mixed findings in the literature (Helgeson et al., 2006; Linley & Joseph, 2004; Liu et al., 2017; Shakespeare-Finch & Lurie-Beck, 2014), including relations between PTG and lower levels of negative outcomes in some cases (Frazier et al., 2001; Lee et al., 2019; Lev-Wiesel & Amir, 2003) and relations between PTG and elevated levels of negative outcomes (Greene et al., 2015; Hamam et al., 2020; Lahav, Bellin, et al., 2016; Lahav, Kanat-Maymon,

et al., 2017; Lahav, Solomon, et al., 2016), in others. The former findings might reflect an authentic positive transformation, which could be adaptive, whereas the latter might reflect dissociation-based beliefs of PTG, which could exacerbate survivors' distress (Lahav, Bellin, et al., 2016).

This prospect is further implied by the present results indicating heterogeneity among adult survivors concerning patterns of PTG, dissociation, and IWA. Our findings revealed three distinct profiles reflecting high, medium, and low scores (on PTG, dissociation, and IWA), and furthermore indicated that profile type explained survivors' PTSD and anxiety symptoms, even after controlling for gender, age, and abuse severity. Specifically, we found that participants with high PTG, dissociation, and IWA had the highest scores on PTSD and anxiety symptoms, following participants with medium levels of PTG, dissociation, and IWA, following participants with low levels of PTG, dissociation, and IWA.

It could be that these distinct profiles reflect the degree to which defensive mechanisms are involved in reports of PTG, with the "high" profile representing PTG that is more likely to be dissociation-driven and related to survivors' identifying with their perpetrators, compared to the other two profiles. Although these dissociation-based PTG beliefs might provide relief during the abuse, they might be counterproductive after the abuse has ended. Similar to other byproducts of dissociation, these beliefs might impede survivors' ability to work through their abuse, intensify their avoidance tendencies, and even increase their risk for revictimization (Lahav, Bellin, et al., 2016; Lahav, Ginzburg, et al., 2020). Hence, survivors who hold such beliefs might suffer from elevated levels of psychopathology, as manifested, in the present study, in higher levels of PTSD and anxiety symptoms.

The current study had several limitations. First, a major limitation was its cross-sectional design, which limits the ability to determine the associations' directionality. Second, it relied on convenience sampling and self-report measures, which may be subject to response biases and shared method variance. Furthermore, this study included data regarding PTG, IWA and dissociation decades after the abuse. Evidence suggests that individuals' capacity to assess personal change over time, such as positive change after adversity may be limited (Frazier et al., 2009). Thus, one may ponder whether the assessment of PTG so many years after the abuse mirrors growth or alternatively a biased recording of past experience. Finally, this study was conducted among Israeli survivors of childhood abuse, thus limiting its generalizability, and explored the contribution of distinct profiles of PTG, IWA and dissociation in explaining psychopathology only. In order to shade light on the implications of profiles of PTG, IWA and dissociation for survivors' experience, future studies should explore these variables over time and assess their contribution in explaining both psychopathology and quality of life among survivors of various interpersonal traumas with diverse cultural backgrounds.

Bearing in mind these limitations, this study provides a nuanced look at the nature of PTG reports among abuse survivors. Although the present evidence is preliminary, it suggests that whereas some childhood abuse survivors might experience authentic growth in the aftermath of their abuse, others' PTG reports might be dissociation-based and/or related to their strong bonds with their perpetrators. Although dissociation-driven beliefs of PTG could ease the pain during the abuse, the present findings imply that they may contribute to elevated distress and psychopathology after the abuse has ended and be related to elevated PTSD and anxiety symptoms. Clinicians should therefore try to avoid taking childhood abuse survivors' reports of PTG at face value and instead take into account their dissociation and IWA. Nevertheless, more research exploring the relations between PTG, dissociation, and IWA over time and among survivors of various interpersonal traumas is needed so as to further clarify the multifaceted nature of PTG and to translate this knowledge into the clinical realm.

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Data availability statement

Due to the nature of this research, participants of this study did not agree for their data to be shared publicly, so supporting data is not available.

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