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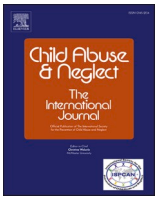

Complex PTSD and identification with the aggressor among survivors of childhood abuse

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ABSTRACT

Background: Childhood abuse (CA) is a risk factor for trauma-related disorders including post-traumatic stress disorder (PTSD) and complex posttraumatic stress disorder (CPTSD). This severe form of interpersonal trauma may result in "identification with the aggressor" (IWA), in which the individual may take on the beliefs, perspectives, and behaviors of the perpetrator. Although previous evidence suggests that IWA may be particularly related to CPTSD as compared to PTSD, there has been no study that investigated this hypothesis.

Objective: The current study explored the relations between IWA and PTSD and CPTSD symptoms, and the contribution of IWA to the excess probability of PTSD and CPTSD classifications, as compared to no classification.

Participants and setting: This cross-sectional study was conducted among 320 Israeli adult CA survivors aged 21–63 (M = 42.04, SD = 10.81).

Methods: An online survey was completed by a convenience sample of adult CA survivors.

Results: Replacing one's agency with that of the perpetrator as part of IWA had a significant effect on both PTSD and CPTSD symptoms (ES = 0.36 and 0.24, respectively), and served as a risk factor for both PTSD and CPTSD classifications. Moreover, analysis of the models' predicted values reveals that the predicted probability of CPTSD classification was 3 to 5 times higher than on the probability of PTSD classifications, for low to high values of the replacing one's agency scale, respectively.

Conclusions: The current findings suggest that IWA may describe some of the deep and long-lasting detriments of CA on self, and may contribute to the development of CPTSD symptoms.

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1. Introduction

Childhood abuse (CA; i.e., emotional, physical, or sexual abuse during childhood) is a widespread, global problem that greatly hinders the well-being of millions of children worldwide (Stoltenborgh et al., 2015). Recent estimates indicate that 36 % of children worldwide experience emotional abuse, 23 % physical abuse, and 18 % of girls and 8 % of boys have been subjected to sexual abuse (World Health Organization; WHO, 2019). A study conducted among 6th, 8th and 10th grade students in Israel, indicated a prevalence of 31.1 % for emotional abuse, 18.0 % for physical abuse, and 18.7 % for sexual abuse (Lev-Wiesel et al., 2018).

Childhood abuse is a non-specific risk factor for a number of conditions. These include depression (Li et al., 2016; Lindert et al., 2014; Nelson et al., 2017), anxiety (Li et al., 2016; Lindert et al., 2014), dissociation (Vonderlin et al., 2018), substance-use disorders (Halpern et al., 2018), non-suicidal self-injury (Ford & Gómez, 2015), eating disorders (Molendijk et al., 2017), body dysmorphic symptoms (Longobardi et al., 2022), sexual dysfunction (Gewirtz-Meydan & Lahav, 2020a, 2020b), poor physical health (Wegman & Stetler, 2009), and trauma-related disorders (Gardner et al., 2019; Messman-Moore & Bhuptani, 2017).

Survivors of CA are likely to report Posttraumatic stress disorder (PTSD) symptoms, which consist of three symptom clusters relating to the traumatic event: re-experiencing trauma in the present, avoiding traumatic reminders, and a heightened sense of threat (World Health Organization, 2022). Re-experiencing trauma symptoms reflect one's experience of the past trauma as re-occurring in the here and now, and include vivid intrusive memories/images, flashbacks and nightmares. Avoiding traumatic reminders symptoms consist of active internal avoidance of thoughts and memories linked to the trauma, or external avoidance of people, conversations, activities, or situations reminiscent of it. Lastly, persistent perceptions of heightened current threat include symptoms such hypervigilance, enhanced startle response, and constantly being on guard.

Nonetheless, exposure to repeated, protracted interpersonal trauma (Cloitre, 2020; Herman, 1992b; Maercker et al., 2022; van der Kolk et al., 2005), such as CA, could have pervasive and long-lasting effects, and thus may result in widespread and persistence damages to basic functions of the self beyond PTSD. Complex Posttraumatic Stress Disorder (CPTSD), which was introduced in ICD-11, reflects these impacts and comprises six symptom clusters: the three PTSD clusters and additional three symptom clusters described as "disturbances in self-organization" (DSO) that include affect dysregulation, persistent negative self-concept, and persistent difficulties in forming and maintaining relationships. The affect dysregulation cluster includes symptoms that reflect severe and pervasive difficulties in regulating affect, such as heightened emotional reactivity to minor stressors, violent outbursts, reckless or self-destructive behavior, dissociative symptoms, and emotional numbing. Persistent negative self-concept cluster comprises of views of oneself as diminished, defeated or worthless, accompanied by profound feelings of shame, guilt or failure. Lastly, persistent difficulties in forming and maintaining relationships cluster includes consistent avoidance or limited interest in relationships and social engagement, or alternatively forming relationships that are found difficult to sustain.

Prevalence estimates for CPTSD based on the ICD-11 definition in adult non-clinical populations range from 0.5 to 7.7 % (Ben-Ezra et al., 2018; Cloitre et al., 2019; Hyland et al., 2021; Hyland, Karatzias, et al., 2020; Hyland, Shevlin, et al., 2020; Maercker et al., 2018), and it has been commonly observed among clinical samples (Møller et al., 2020). Compared to PTSD, CPTSD is more often observed in people with a history of childhood trauma (Cloitre et al., 2019); and CPTSD is more strongly related to poorer functional impairment and to other co-morbid difficulties, such as depression, generalized anxiety, and dissociation (Hyland et al., 2018; Karatzias et al., 2017; van Dijke et al., 2012).

A relational dynamic of CA that has been described in the theoretical and empirical literature is the occasional formation of particularly strong bonds between CA victims and their perpetrators, a phenomenon known as *identification with the aggressor* (IWA; Lahav, Talmon, & Ginzburg, 2019). The concept of IWA, originally developed by Ferenczi (1932, 1933), is proposed to serve as a mechanism promoting victims' survival during the abuse by their taking on and adopting their perpetrators' experience (Amir, 2016; Coates & Moore, 1997; Lahav, Talmon, & Ginzburg, 2019). IWA allows the victim to maintain a positive relationship with the perpetrator and is not limited to CA perpetrated by a parental figure (Lahav, 2021a, 2022; Lahav, Talmon, & Ginzburg, 2019). It may develop as a result of power asymmetry between the victim and perpetrator, when the victim cannot escape, evade, or prevent the attacks (Frankel, 2002), and therefore can include other relationships, such as in intimate partner violence (Lahav, 2021a).

IWA entails four intertwined components described in the following section: replacing one's agency with that of the perpetrator; becoming hypersensitive to the perpetrator; adopting the perpetrator's experience concerning the abuse; and identifying with the perpetrator's aggression (Lahav, Talmon, & Ginzburg, 2019). To anticipate and endure the attacks, as well as to decrease hazards, abused individuals develop (dissociated) self-states that identify with the aggressor (Amir, 2016; Lahav, Talmon, & Ginzburg, 2019). Victims of abuse undergo the *replacement of their own agency with that of the perpetrator*, losing connection to their own feelings, urges and needs, and becoming passive and obedient not only behaviorally but also mentally. They develop *heightened sensitivity towards their perpetrators*, by becoming highly attuned and learning their perpetrators' feelings, needs, moods and intentions, as well as who their perpetrators want them to be, and how to appease their perpetrators. At the same time, they *adopt their perpetrators' experience concerning the abuse*, feeling what their perpetrators feel, and holding their perpetrators' views and beliefs concerning the abuse. Thus, abuse victims may not only detach from their pain, but may also deny, minimize and even justify their abuse (Lahav et al., 2017; Sultana & Lahav, 2023). Lastly, they *identify with their perpetrators' aggression*, internalizing their perpetrators' violent and sadistic urges

(Frankel, 2002; Lahav et al., 2020). This process may result in victims directing aggression towards both themselves and others (Frankel, 2002; Lahav et al., 2020). Two types of identification are involved: concordant identification, in which victims mold their experience of *themselves* upon the perpetrators' experience of *themselves* and thus they adopt their perpetrators' aggression towards others; and complementary identification, where victims identify with their perpetrators' perceptions of the "*other*," and view themselves as bad and warrant being the victim of other's aggression.

Although IWA is assumed to be an automatic reaction that promotes survival during abuse (Frankel, 2002), it may become entrenched and persist long after the abuse has ended, at which point it becomes highly damaging (Lahav, Talmon, & Ginzburg, 2019). Given that IWA requires a splitting-off of parts of one's experience (i.e., dissociation), it has been claimed to hinder the processing of the trauma (Frankel, 2002). Furthermore, forming emotional bonds with the perpetrator and adopting their perspective and emotions concerning the abuse, has been claimed to result in reliving of the past trauma and thus to hamper recovery, and to exacerbate distress (Lahav, 2021b; Lahav, Talmon, & Ginzburg, 2019). Recent evidence supports these claims, indicating associations between IWA and various negative outcomes among adult survivors of CA, among the most commonly found being dissociation, non-suicidal self-injury, sexual revictimization, suicidal ideation and behavior, as well as PTSD symptoms (Lahav, 2021b; Lahav et al., 2020; Lahav, Talmon, & Ginzburg, 2019; Rosenberg et al., 2023).

Nevertheless, to the best of our knowledge, the relationship between IWA and CPTSD has yet to be investigated. Furthermore, no empirical investigation has uncovered the contribution of IWA to CPTSD versus PTSD symptomatology and classification among CA survivors. This is surprising given that the affiliative and complex attachment between CA victims and their perpetrators, reflected in the IWA concept, has been documented long ago in renowned scholars' writings (Dutton & Painter, 1993; Graham et al., 1994); and given that IWA has been claimed to not only exacerbate posttraumatic distress, but also and even more so to negatively shape victims' intrapersonal as well as interpersonal capacities (Ferenczi, 1932, 1933; Frankel, 2002), which are common in the disturbances of self-organization clusters of CPTSD.

Thus, IWA may contribute to generation of CPTSD symptoms among CA survivors. Moreover, whereas elevated IWA may pertain to both PTSD and CPTSD symptomatology, due to its general maladaptive quality (Lahav, Talmon, & Ginzburg, 2019), one may expect it to be more strongly associated with CPTSD than PTSD, considering the expected high degree of association between IWA and disturbances in self-organization. The present study explored the following hypotheses: (1) IWA would be related to PTSD and CPTSD symptoms; (2) IWA would contribute to explaining PTSD and CPTSD symptomology; and (3) IWA would contribute to the excess probability of PTSD and CPTSD classifications, as compared to no classification (the reference category), and would have a more pronounced contribution to the predicted probability of CPTSD classification as compared to PTSD classification.

2. Methods

2.1. Subjects and procedure

An online survey was conducted among a convenience sample of Israeli adults. A link to a secure web-based survey data collection system was published on social media platforms (e.g., Facebook) and was accessible through Qualtrics. The survey was advertised as a study exploring the implications of adverse life events among adults (age of 18 and above), took an average of 20 min to complete, and was open from September 15, 2021 to November 15, 2021. Built-in option of the Qualtrics platform ('Skip to' and 'Prevent Ballot Box Stuffing') were used to ensure that only individuals of age of 18 or above participate in the survey, and to avoid duplicative entries to the survey.

The survey was anonymous, and no data were collected linking participants to recruitment sources. Furthermore, to protect participants' privacy, IP addresses were deleted from the dataset and were replaced by random ID numbers. The Tel Aviv University institutional review board approved all procedures and instruments.

Clicking on the link to the survey guided potential respondents to a page with information about the purpose of the study, the nature of the questions, and a consent form. It also included the researcher's contact information and several Israeli organizations that provide support/treatment for CA. Each participant was invited to take part in a lottery for four $30 gift vouchers.

A total of 577 people responded to the survey. Of them, 320 (55.5 %) reported a history of CA based on the short form of the Childhood Trauma Questionnaire (SF-CTQ; Bernstein et al., 2003) and provided data regarding the variables included in the current analyses (see Table 1).

Participants were classified as having a history of abuse if they had scores on the SF-CTQ that were higher than the cutoff scores suggested by Tietjen et al. (2010): physical abuse $\geq$8; sexual abuse $\geq$6; and emotional abuse $\geq$9. Of this sample, 145 (45.3 %) had a history of childhood physical abuse; 235 (73.4 %) had a history of childhood sexual abuse; and 258 (80.6 %) had a history of childhood emotional abuse. Around a third of the sample ($n = 97$, 30.3 %) was classified as having a history of one type of abuse, whereas the majority of the sample ($n = 223$, 69.7 %) was classified as having a history of at least two types of abuse (i.e., polyvictimization): 128

Table 1
Description of demographic characteristics among participants ($n = 320$).

		M (SD) or n (%)
Age, M (SD)		42.04 (10.81)
Gender		
	Men	41 (12.8)
	Women	279 (87.2)
Education, n (%)		
	High school diploma or less	53 (16.6)
	Some higher education	68 (21.3)
	Bachelor's degree	112 (35.0)
	Master's degree and above	85 (26.5)
	Other	2 (0.6)
Relationship status, n (%)		
	In a relationship	177 (55.3)
	Not in a relationship	142 (44.4)
	Other	1 (0.3)
Religiosity, n (%)		
	Secular	226 (70.6)
	Religious/traditional	75 (23.5)
	Other	19 (5.9)
Employment status, n (%)		
	Working in a full or part-time job	237 (74.1)
	Not working	49 (15.9)
	Other	34 (10.6)
Income, n (%)		
	Below-average income	163 (50.9)
	Average income or above	157 (49.1)
Age when abuse begun		8.59 (3.95)
Recurrence of the abuse		
	Recurrent abuse	249 (77.8)
	Single episode of abuse	71 (22.2)
Role of the perpetrator		
	Extra-familial figure	122 (38.1)
	Family member	62 (19.4)
	Parental figure	136 (42.5)
Polyvictimization		
	Single type of abuse	97 (30.3)
	Two types of abuse or more	223 (69.7)

(40.0 %) were classified as having a history of two types of abuse, and 95 (29.7 %) were classified as having a history of all three types of abuse.

The average age that abuse happened or began was 8.59 years (SD = 3.95), and the majority of the sample reported recurrent abuse inflicted by an attachment figure. As it can be seen in Table 1, most of the participants were women, secular, and had a bachelor's degree or above. The majority reported having below the average income, and indicated being in a relationship.

2.2. Measures

2.2.1. Background variables

Participants completed a brief demographic questionnaire assessing age, gender, education, and relationship status.

2.2.2. Features of abuse

Participants with a history of CA were asked to specify several features of abuse: (1) their age when the abuse begun; (2) whether the abuse had been a one-time event or recurrent; (3) the role of the perpetrator in their lives, namely whether the perpetrator was a parental figure (e.g., parents, adopted parents), a non-parental family member (e.g., siblings, cousins), or an extra-familial figure (e.g., neighbours, friends of the family). Additionally, as mentioned, exposure to one type of abuse versus polyvictimization was based on participants' responds to the SF-CTQ (Bernstein et al., 2003).

2.2.3. Classification and Symptoms of PTSD and CPTSD

The International Trauma Questionnaire (Cloitre et al., 2018), a self-report scale, was used to measure symptoms of ICD-11 PTSD and CPTSD in the aftermath of CA. Respondents who reported a history of CA were instructed to answer all questions in relation to CA. There are six items measuring PTSD symptoms across the clusters of 'Re-experiencing in the here and now,' 'Avoidance,' and 'Sense of Threat.' These items are answered in terms of how much the respondent has been bothered by that symptom in the past month. Three questions measure functional impairment in the social, occupational, and other important domains. An additional six items measure DSO symptoms across the clusters of 'Affective Dysregulation,' 'Negative Self-Concept,' and 'Disturbed Relationships.' The DSO symptoms are answered in terms of how respondents typically feel, think about themselves, and relate to others. Three further items

measure functional impairment associated with these symptoms. All items are answered on a five-point Likert scale that ranges from 0 (Not at all) to 4 (Extremely), and a symptom is considered to be present based on a score of ≥2 (Moderately) on the Likert scale.

For a probable diagnosis of PTSD, at least one symptom must be present from each cluster, and at least one indicator of functional impairment associated with these symptoms must be endorsed. For a probable diagnosis of CPTSD, at least one symptom must be present for each of the six symptom clusters, and endorsement of functional impairment associated with the PTSD and DSO symptoms must be present. As per the ICD-11 diagnostic guidelines, a person may only belong to PTSD or CPTSD classification, but not both.

The ITQ was validated for screening ICD-11 PTSD and CPTSD symptomatology (Cloitre et al., 2018), and its Hebrew version, which was utilized in the current study, was validated in previous research (Ben-Ezra et al., 2018; Gilbar et al., 2018). In this study, the internal consistency was high: α = 0.89, α = 0.89 and α = 0.92 for PTSD symptoms, DSO symptoms, and the 12 items of the scale.

2.2.4. Identification with the aggressor

The Identification with the Aggressor Scale (IAS) is a 23-item self-report questionnaire (Lahav, Talmon, & Ginzburg, 2019), that was utilized to assess IWA. The items were presented 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, calculated by averaging the relevant items: 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"), becoming hypersensitive to the perpetrator (4 items; e.g., "Some people 'read the thoughts' of their perpetrator"), 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"), and identifying with the perpetrator's aggression (5 items; e.g., "Some people feel that they behave as aggressively as their perpetrator"). In addition, we used the IAS total score, calculated by averaging all 23 items. The IAS has been shown to have high construct and criterion validity, as well as high internal reliability among adult Israeli participants ((Lahav, Talmon, & Ginzburg, 2019). In this study, the internal consistency was high: α =0.82, α =0.87, α =0.90, α =0.95, and α =0.94 for the four subscales and the total score.

2.3. Data analysis

Analyses were performed using R software. No missing data were present. Outlier observations were tested via Mahalanobis' distance measure. No outliers were detected. To explore the relations between IWA and symptoms of PTSD and CPTSD, correlation analyses were conducted, using Pearson's correlation coefficient where applicable, and Kendall's τ_B and τ_C where values were limited to less than four values (i.e., in the PTSD and CPTSD subscales; Hollander & Wolfe, 1999). All continuous data were tested for univariate and multivariate normality, using the Shapiro Wilk test and the Mardia test.

To explore the contribution of IWA in explaining PTSD and CPTSD symptoms, a path analytics scheme was applied. Since the data violated the multivariate normality assumption, a maximum likelihood (ML) estimation technique could not be applied. To guarantee unbiased and efficient estimators, we applied ML with robust standard errors, and the Satorra-Bentler scaled test statistics (Chou et al., 1991). Model fit was tested using the Normed chi square value, RMSR, RMSEA and the p-close test, and the appropriate incremental fit indices (CFI, NFI, IFI, and TLI). We performed all analyses twice to test for the contribution of covariates (i.e., age, gender, recurrence of the abuse, age when abuse begun, polyvictimization, the role of the perpetrator in their lives) using the Satorra and Bentler (2001) scaled difference Likelihood Ratio (LR) test for nested models. We tested for multicollinearity in both the measurement and structural models by estimating the Variance Inflation Factor of each variable, setting a highly conservative threshold of VIF < 4, as suggested by O'brien (2007).

To explore the likelihood of PTSD and CPTSD classifications (as compared to the no classification–the reference category) as a function of IWA, we applied an ordinal logistic regression scheme. We tested for the proportional odds assumption of the model, using the parallel assumption LR test, and added individual slopes for variables that failed to meet the assumption, as suggested by Peterson and Harrell Jr (1990). Model diagnostics included calculating of the Cragg and Uhler (Nagelkerke) pseudo-R^2 value, and the Lipsitz goodness of fit test for ordinal response models (Lipsitz et al., 1996). We estimated the ordinal models twice: with and without covariates. The contribution of the additional variables to the models was estimated using the cumulative link models' LR test (Christensen, 2018). To estimate the effect of each significant IWA subscale on the probability of PTSD and CPTSD classifications, we estimated probabilities for each classification using the model's predicted values for the entire range of the data.

3. Results

3.1. Descriptive statistics

In total, 5.3 % of the sample met requirements for PTSD classification, and an additional 15.3 % met requirements for CPTSD classification. Frequencies of symptom cluster endorsement were as follows: the most commonly endorsed symptom cluster was Affective Dysregulation (72.2 %), followed by Disturbed Relationships (60.9 %), Sense of Current Threat (51.6 %), Negative Self-concept (48.8 %), Avoidance (44.4 %), and Re-experiencing (27.8). As shown in Table 2, correlation analyses indicated positive and statistically significant associations between IWA subscales and all PTSD and DSO symptom clusters, as well as total scores.

Table 2
Associations between Identification with the Aggressor and Symptoms of PTSD and CPTSD (n = 320).

	1	2	3	4	5	6	7	8	9	10	11	12
1. Adopting the perpetrator's experience concerning the abuse	–											
2. Identifying with the perpetrator's aggression	0.71***	–										
3. Replacing one's agency with that of the perpetrator	0.56***	0.46***	–									
4. Becoming hyper-sensitive to the perpetrator	0.66***	0.51***	0.52***	–								
5. Identification with the aggressor (total score)	0.91***	0.83***	0.75***	0.79***	–							
6. Re-experiencing	0.21***	0.15***	0.25***	0.22***	0.25***	–						
7. Avoidance	0.20***	0.13**	0.23***	0.14**	0.22**	0.42***	–					
8. Sense of threat	0.19***	0.13**	0.27***	0.16***	0.23***	0.40***	0.50***	–				
9. Affective dysregulation	0.11***	0.11*	0.17***	0.14**	0.16***	0.40***	0.39***	0.45***	–			
10. Negative self concept	0.17***	0.16***	0.19***	0.10*	0.19***	0.25***	0.32***	0.33***	0.48***	–		
11. Disturbed relationships	0.17***	0.20***	0.21***	0.15***	0.22***	0.26***	0.34***	0.42***	0.57***	0.52***	–	
12. PTSD total score	0.27***	0.18**	0.38***	0.26***	0.32***	0.68***	0.79***	0.80***	0.51***	0.40***	0.46***	–
13. CPTSD total score	0.21***	0.23***	0.28***	0.20***	0.28***	0.38***	0.42***	0.46***	0.77***	0.76***	0.79***	0.57***

NOTE: Kendall's τ_B and Kendall's τ_C serve as a measure of association, where Pearson correlation is inapplicable.

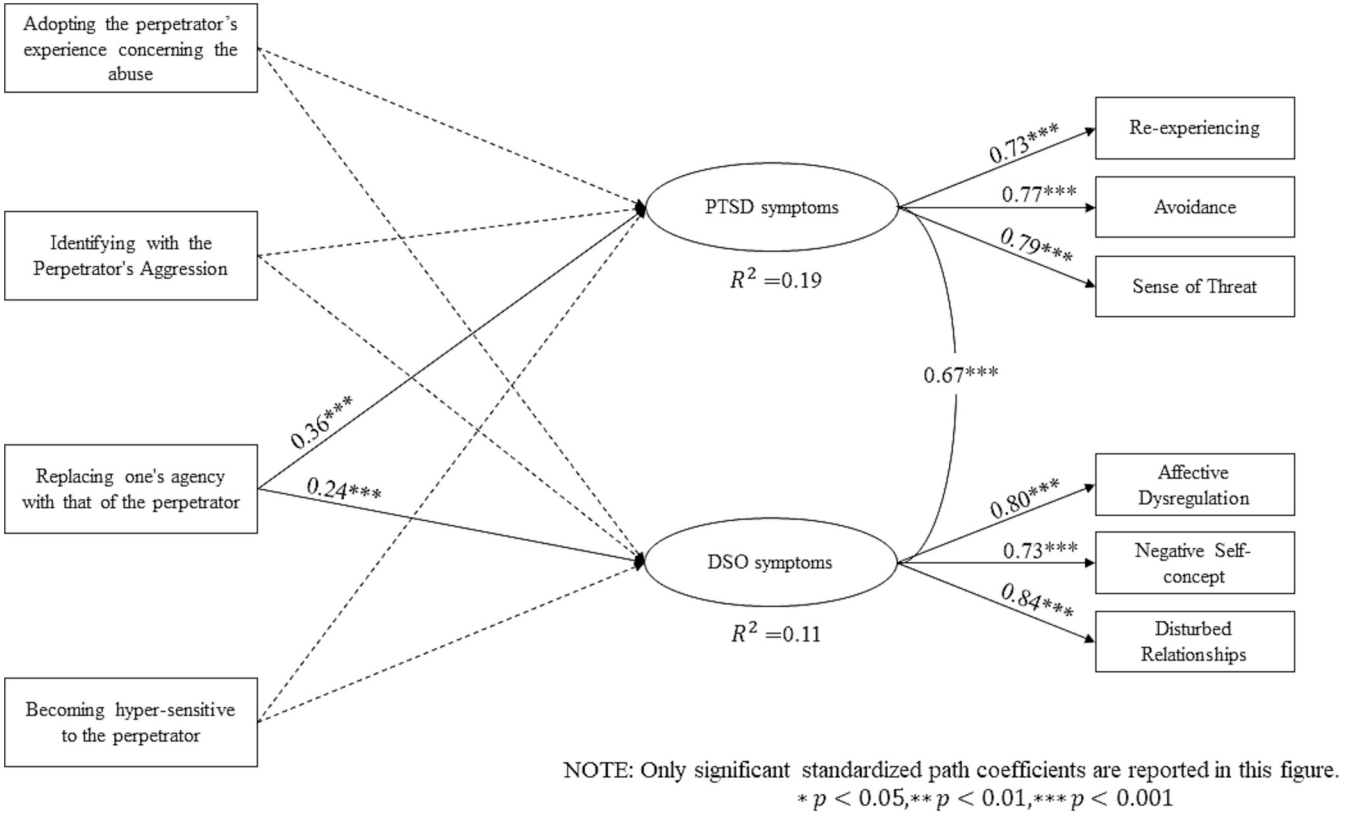

Fig. 1. Results of path analysis for the contribution of IWA to the latent traits of PTSD and CPTSD.

Table 3
Results of the structural equations modeling for a constrained and unconstrained model.

Measurement model		Constrained model $\widehat{\beta}$ (SE)	Unconstrained model $\widehat{\beta}$ (SE)
PTSD	Re-experiencing	0.733***	0.729***
		(0.033)	(0.033)
	Avoidance	0.775***	0.773***
		(0.034)	(0.035)
	Sense of threat	0.789***	0.794***
		(0.03)	(0.031)
DSO	Affective dysregulation	0.797***	0.795***
		(0.031)	(0.031)
	Negative self-concept	0.731***	0.734***
		(0.035)	(0.035)
	Disturbed relationships	0.844***	0.843***
		(0.03)	(0.03)

Structural model	$\widehat{\beta}$ (SE) PTSD	$\widehat{\beta}$ (SE) DSO	$\widehat{\beta}$ (SE) PTSD	$\widehat{\beta}$ (SE) DSO
Adopting the perpetrator's experience concerning the abuse	0.103	−0.049	0.084	−0.059
	(0.104)	(0.103)	(0.099)	(0.101)
Identifying with the perpetrator's aggression	−0.082	0.151	−0.101	0.137
	(0.089)	(0.084)	(0.089)	(0.084)
Replacing one's agency with that of the perpetrator	0.364***	0.241***	0.345***	0.222***
	(0.061)	(0.073)	(0.061)	(0.072)
Becoming hyper-sensitive to the perpetrator	0.077	0.051	0.019	0.016
	(0.089)	(0.079)	(0.088)	(0.081)
Recurrence of the abuse			−0.103	−0.057
			(0.058)	(0.062)
Age when abuse begun			−0.039	0.009
			(0.058)	(0.06)
Polyvictimization			−0.177***	−0.19***
			(0.052)	(0.057)
Role of the perpetrator (parental figure)			0.009	0.01
			(0.074)	(0.075)
Role of the perpetrator (family member)			−0.116	−0.097
			(0.062)	(0.065)
Age			−0.114*	−0.051
			(0.057)	(0.059)
Gender			0.053	0.016
			(0.057)	(0.061)
R^2	**0.19**	**0.11**	**0.26**	**0.16**

***$p < 0.001$,**$p < 0.1$,*$p < 0.05$.

3.2. The contribution of IWA in explaining PTSD and CPTSD symptoms

Fig. 1 presents the results of the path analysis. While the Satorra-Bentler normed χ^2 was significant in our model ($\chi^2(24) = 42.54$, $p = .011$), we took into consideration its sensitivity to the sample size and used a set of additional indices to determine the fit of the model to the data. All model fit indices indicated an excellent fit of the model to the data (CFI = 0.98, NFI = 0.96, IFI = 0.98, TLI = 0.97), and a good fit of the model-based covariance matrix to the actual covariance-matrix (RMSR = 0.03, RMSEA = 0.049 with CI = [0.024, 0.072], and p-clove PV = 0.49). All VIF values for the exogenous and latent variables in the model were below the common threshold ($1.56 < \text{VIF} < 2.84$).

We repeated the analysis for a model including the features of abuse variables and the covariates (age, and gender). The inclusion of features of abuse variables and the covariates did not improve the model's fit, nor did the scaled difference likelihood-ratio test yield a significant difference between the models (Table 3). Of IWA subscales, only *replacing one's agency with that of the perpetrator* had a significant effect in explaining symptoms of PTSD ($\beta = 0.36, SE = 0.06, p < 0.001$) and DSO ($\beta = 0.24, SE = 0.073, p < 0.001$). The model also affirmed a positive and significant correlation between PTSD and DSO ($r = 0.67, SE = 0.048, p < 0.001$). As for the explanatory power of the measurement model, IWA explained 19 % and 11 % of the variation in PTSD symptoms and DSO symptoms, respectively ($R^2 = 0.19, R^2 = 0.11$).

3.3. IWA and PTSD and CPTSD classifications

We began by estimating the effect of the four IWA dimensions on the odds of PTSD and CPTSD classifications, as compared to the no

classification in a model excluding covariates. We corrected the model for the failure of identifying with the perpetrator's aggression subscale to meet the proportional odds assumption ($\chi_1^2 = 4.77, p = 0.03$) and estimated a partial proportional odds ordinal model. Then, we estimated a model in which features of abuse and covariates were included. The second model was also corrected for the failure of the identifying with the perpetrator's aggression subscale and of polyvictimization to meet the proportional odds assumption ($\chi_1^2 = 4.61, p = 0.03$ *and* $\chi_1^2 = 10.03, p = 0.002$, respectively). Results of the LR test revealed that including the covariates in the model significantly contributed to the explanatory power of the model ($\chi_8^2 = 19.78, p = 0.01$). The model's explanatory power over the null model was 0.11.

The *replacing one's agency with that of the perpetrator* subscale had a significant effect on the probability of belonging to either PTSD or CPTSD classifications ($\widehat{\beta} = 0.024, p < 0.001$), where an increase of 1 point in the *replacing one's agency with that of the perpetrator* score increased the odds of a classification by 1.02. Polvictimization also significantly affected the probability of PTSD ($\widehat{\beta} = 0.93, p = 0.017$) and CPTSD ($\widehat{\beta} = 2.17, p = 0.003$) classifications, so that individuals subjected to polvictimization were 2.54 times more likely to belong to the PTSD classification, and 8.75 times more likely to receive a PTSD or CPTSD classification. The full results of the Ordinal Logistic Regressions are presented in Table 4.

Predicted probability of each classification, given the range of possible values of the *replacing one's agency with that of the perpetrator* scores, is described in Fig. 2. An increase in the *identifying with the perpetrator's aggression* score decreases the probability of a no trauma classification, increases the probability of CPTSD classification, and moderately increases the probability of PTSD classification. The probability of a CPTSD classification was higher than that of a PTSD classification, and the gap between the two is commensurate with the level of the *replacing one's agency with that of the perpetrator* score. Predicted probability of classifications for the minimal, maximal, and quartile values of the *agency replacing* score are given in Table 5.

Table 4
Results of the Ordinal Logistic Regression (partial proportional odds) for a constrained and unconstrained model.

	Constrained model						Unconstrained model					
	$\widehat{\beta}$	OR	None| PTSD	OR	PTSD| CPTSD	OR	$\widehat{\beta}$	OR	None| PTSD	OR	PTSD| CPTSD	OR
Intercept			3.05*** (0.39)		3.73*** (0.43)				1.50 (0.96)		1.98 (0.98)	
Adopting the perpetrator's experience concerning the abuse	0.004 (0.01)	1					0.003 (0.01)	1				
Replacing one's agency with that of the perpetrator	0.025*** (0.01)	1.02					0.024*** (0.01)	1.02				
Becoming hyper-sensitive to the perpetrator	0.008 (0.01)	1					0.005 (0.01)	1				
Identifying with the perpetrator's aggression [A]			0.005 (0.01)	1	−0.002 (0.01)	1			0.005 (0.01)	1	0 (0.01)	1
Recurrence of the abuse							−0.476 (0.48)	0.62				
Age when abuse begun							−0.035 (0.04)	0.97				
Role of the perpetrator (family member)							−0.242 (0.39)	0.78				
Role of the perpetrator (parental figure)							−0.573 (0.46)	0.56				
Age							−0.015 (0.01)	0.99				
Gender(female)							0.082 (0.46)	1.09				
Polyvictimization[A]									0.93* (0.41)	2.54	2.17** (0.74)	8.75

***p < 0.001,**p < 0.1,*p < 0.05.

[A] The variable failed to meet the proportional odds assumption and was modelled under the assumption of separate slopes for each outcome.

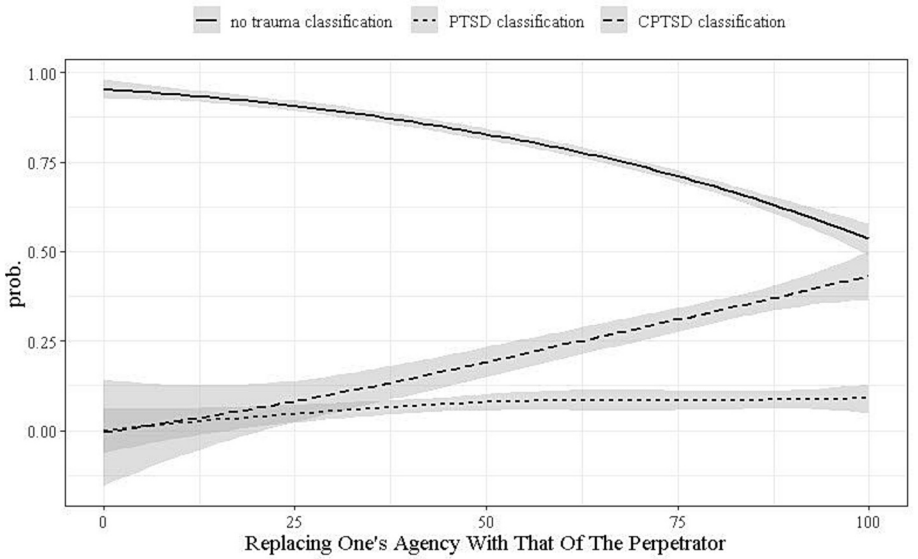

Fig. 2. Predicted probability of no classification, PTSD classification, and CPTSD classification, given the score of the replacing one's agency with that of the perpetrator.

Table 5
Predicted probabilities of no classification, PTSD, and CPTSD classifications for common distribution indices of the replacing one's agency with that of the perpetrator score.

Index	Replacing one's agency with that of the perpetrator value	No classification	PTSD classification	CPTSD classification
Minimum	0	0.90	0.03	0.07
Q1	28	0.82	0.04	0.13
Q2	51	0.73	0.06	0.21
Q3	72	0.62	0.07	0.30
Maximum	100	0.46	0.08	0.46

4. Discussion

This study investigated the relationship between IWA, PTSD, and CPTSD among CA survivors. The results revealed significant associations between all IWA subscales and total score, and symptoms of both PTSD and CPTSD. Results also indicated that replacing one's agency with that of the perpetrator, as part of IWA, had a significant and positive effect on both PTSD and CPTSD symptoms, and that it served as a risk factor for both PTSD and CPTSD classifications as compared to no classification. Moreover, the effect of replacing one's agency with that of the perpetrator on the probability of a CPTSD classification was 3 to 5 times higher than on the probability of PTSD classification, for low to high values of the scale, respectively. These findings suggest that IWA may describe some of the vast, deep, and long-lasting detriments of CA on one's self, that are present in CPTSD.

Associations were found between IWA subscales and total score and symptoms of both PTSD and CPTSD. The higher the levels of IWA, the higher the levels of PTSD and CPTSD symptomatology. These findings corroborate research indicating relations between IWA and intensified posttraumatic distress (Lahav, 2021a; Lahav, Talmon, & Ginzburg, 2019; Siegel et al., 2022; Sultana & Lahav, 2023). Forming strong bonds with the perpetrator may have beneficial effects during the abuse by enabling the individual to predict attacks, appease the perpetrator, and prevent escalations, as well as preserve positive relations that may be essential for physical and emotional well-being (Ferenczi, 1932, 1933; Frankel, 2002; Lahav, Talmon, & Ginzburg, 2019). Nonetheless, habitual IWA that persists after the abuse ends may have substantial disadvantageous effects, and may lead to denying or minimizing the abuse, blaming oneself, and internalizing aggression (Lahav et al., 2020; Siegel et al., 2022).

Moreover, IWA relies upon dissociative mechanisms and thus limits survivors' ability to re-process the trauma and form an integrated and stable belief system. Additionally, IWA consists of both concordant and complementary identifications (Frankel, 2002). Molding their experience of themselves upon the perpetrators' experience of themselves, survivors regard the abuse from their perpetrators' perspectives and take on their perpetrators' aggression towards others (i.e., concordant identification). On the other hand, identifying with their attackers' views of the "other," survivors regard themselves as bad and blameworthy (i.e., complementary identification). Thus, survivors who identify with their perpetrators may view themselves, others, and interpersonal relations in a detached and disintegrated way and through the prism of the victim-perpetrator dynamic. They may exhibit greater acceptance of relationships that are emotionally, physically, or sexually abusive, or even hold expectation that close relationships are abusive

relationships (Lahav et al., 2020; Lahav, Talmon, & Ginzburg, 2019). At the same time, they may re-enact the role of the perpetrator, devalue others, and direct aggression towards them (Lahav et al., 2020). These patterns may not only impede survivors' ability to reprocess their traumatic past, as manifested in PTSD symptomatology, but may also lead to deregulation of emotions and impulses, negative self-concept, and difficulties in forming and maintaining relationships, all of which are reflective of CPTSD symptoms (Lahav, 2021b; Lahav et al., 2020; Lahav, Talmon, & Ginzburg, 2019).

The present results indicated that replacing one's agency with that of the perpetrator as part of IWA explained significantly symptoms of PTSD and CPTSD after taking into account varied covariates (age, gender, age when the abuse begun, abuse recurrence, the role of the perpetrator in survivors' lives, and polyvictimization). Moreover, although replacing one's agency with that of the perpetrator was found to serve as a risk factor for both PTSD and CPTSD classifications, it increased the likelihood of CPTSD classification 3 to 5 times in comparison to PTSD classification.

CPTSD in CA survivors reflects profound and enduring impacts of severe interpersonal trauma, impairing self-function, emotion regulation, and interpersonal relationships (Cloitre, 2020; Herman, 1992b; Maercker et al., 2022; van der Kolk et al., 2005). Replacing one's agency with that of the perpetrator as part of IWA appears to reflect a significant impact of abuse that can become entrenched. Although this phenomenon originates in the interpersonal world, its potential implications are particularly impactful in regard to sense of self and regulation of emotions.

Survivors who replace their agency with that of the perpetrator lose their sense of self. Much of their subjective experience becomes dissociated, and their connection with their own feelings, urges, and needs gets lost (Ferenczi, 1933; Frankel, 2002). Their feeling of control over their actions is replaced by the perpetrator's agency, leading to psychological submissiveness. Thus, survivors who replace their own agency with that of the perpetrator not only behave in line with the perpetrator's demands, but become psychologically subordinate to their perpetrators (Lahav, Talmon, & Ginzburg, 2019). Experiencing this aspect of IWA after the abuse ends may severely impair basic functions as manifested in CPTSD. Being disconnected from one's own feelings, urges, and needs may result in perceptions of one's self as unworthy and damaged; may hamper the capacity to detect, understand and regulate one's own emotions; and may lead not only to lack of healthy boundaries, but also to subordination and submissiveness in current relationships (Lahav, Talmon, & Ginzburg, 2019; Lahav, Talmon, Ginzburg and Spiegel, 2019).

As suggested in earlier writings (Herman, 1992a; Roth et al., 1997; van der Kolk et al., 2005), IWA may not only contribute to CPTSD but also be an aspect of it, explaining perplexing behaviors in CA survivors that could pose a substantial obstacle for both treatment and legal processes. These include denial, minimization and rationalization of the abuse, staying in the abusive relationship, defending the perpetrator, as well as re-entering a new abusive relationship, all of which might hinder recovery (Amir, 2016; Davis & Frawley, 1994; Frankel, 2002; Julich, 2005; Lahav, 2022; Lahav, Talmon, & Ginzburg, 2019; Sultana & Lahav, 2023).

The current study had several limitations. First, its cross-sectional design limited the ability to determine the associations' directionality. Second, it relied on a convenience sampling and self-report measures, which may be subject to response biases and shared method variance. Finally, this study was conducted among Israeli survivors of CA, thus limiting its generalizability to other countries and cultures. In order to illuminate the relations among IWA and PTSD and CPTSD, future studies should explore these variables over time via self-report measures and clinical assessment among CA survivors with diverse cultural backgrounds.

Despite these limitations, this study, which has provided the first empirical evidence concerning the relations between IWA and CPTSD, has important clinical implications. Given that CPTSD is a new disorder and evidence concerning effective treatments is limited (Karatzias & Cloitre, 2019), it is essential to identify mechanisms that enable the development of CPTSD symptoms. The current findings suggest that IWA may represent one mechanism for the development of CPTSD symptoms following exposure to CA. Therefore, addressing the internalized abusive dynamic, as reflected in the phenomenon of IWA, and providing skills enabling survivors to overcome this defensive reaction and extricate themselves from the victim-perpetrator roles may benefit survivors and reduce CPTSD symptomatology. Given that IWA has been mainly addressed in psychoanalytic psychotherapies (Frankel, 2002, 2024; Horesh & Lahav, 2024), extending the clinical knowledge in this regard appears to be imperative. Specifically, there is a need to develop clinical tools that target IWA, and to explore their effectiveness within interventions that are often utilized for CPTSD, such as Skills Training in Affective and Interpersonal Regulation and Narrative Therapy (Cloitre & Schmidt, 2022; Karatzias et al., 2024), and Dialectical Behavioural Therapy (Bohus et al., 2013, 2019).

CRediT authorship contribution statement

Yael Lahav: Writing – original draft, Methodology, Formal analysis, Data curation, Conceptualization. **Marylene Cloitre:** Writing – review & editing, Methodology, Conceptualization. **Philip Hyland:** Writing – review & editing, Methodology, Conceptualization. **Mark Shevlin:** Writing – review & editing, Methodology, Conceptualization. **Menachem Ben-Ezra:** Writing – review & editing, Methodology, Conceptualization. **Thanos Karatzias:** Writing – review & editing, Methodology, Conceptualization.

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Data availability

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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