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## **It Gets Better: Childhood Sexual Abuse and Trauma Symptoms in Female Older Adults**

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## Abstract

**OBJECTIVES:** While there has been great deal of research conducted on the effects of child sexual abuse (CSA) on trauma symptoms in children and adults, there is less knowledge on the effects on trauma symptoms in female older adult CSA survivors. The aim of this study was to investigate current symptoms of trauma in adult female survivors of child sexual abuse across each successive decade, beginning with eighteen year olds. **METHODS:** This retrospective, anonymous online study gathered a sample of 223 adult female survivors of CSA (38 of whom were aged 50 – 59 (17%), and 20 of whom were 60+ years of age (9%)), and surveyed their trauma history and their current symptomology. **RESULTS:** In our sample, the survivors with the most severe trauma symptoms were between 18 and 29 years old. Each subsequent decade reported fewer trauma symptoms, with respondents in the 60+ age group reporting the lowest trauma symptom severity. **DISCUSSION:** While a cross sectional study does not allow us to evaluate individuals' experiences over time, these results suggest that the negative impacts of CSA may abate over the life course. Future research should consider these questions longitudinally to explore whether these results are related to survivorship (those with worse outcomes dying younger) and whether these effects endure as female older adults experience physical and mental challenges in later life.

**Keywords:** child sexual abuse, female older adults, trauma, trauma symptoms, depression, anxiety

## **It Gets Better: Childhood Sexual Abuse and Trauma Symptoms in Female Older Adults**

### **Introduction**

Adverse childhood experiences have been linked to poor health and mental health outcomes in adulthood, including chronic disease, negative health behaviors, and early morbidity and mortality (Spencer-Hwang et al., 2018). At the same time, resilience is the occurrence of positive adjustment in the face of challenging life events (Fuller-Iglesias et al., 2008). One way of working with older adults is to view the life as a story in which one's narrative view of the world is constructed by the things they experience in relation to personal and social factors in the context of culture and history (Cappeliez et al., 2008). Embedded in a person's life story are those events in which they place the most meaning (Cappeliez et al., 2008). The life course perspective calls on us to view challenges that occur in late life through the lens of earlier events, particularly adverse events that occur in childhood (Amemiya et al., 2017). One such event that is particularly damaging is child sexual abuse (CSA).

Since most research on adverse childhood experiences examines them in aggregate, little is known about the specific effects of CSA on female older adults. In one of the few studies on the longitudinal effects of CSA on female older adults, Rapsey et al. (2019) sought to examine connections between childhood sexual abuse and polyvictimization (as compared to no maltreatment) on the development of disorders such as anxiety, depression, and PTSD in later life. Their longitudinal study suggested that while childhood sexual abuse was associated with an elevated risk of developing one of these disorders, aging decreased that risk for those with a history of maltreatment. This suggests that perhaps the effects change over time.

### **Adverse Effects of Adverse Childhood Experiences**

Traumatic life events that are experienced in childhood (also known as 'Adverse childhood experiences' (ACEs)) can cause maladaptive effects (i.e., trauma-related symptoms) in

adulthood. These childhood experiences are associated with mental health diagnoses later in life as well as an increased risk of suicidality (Fuller-Thomson et al., 2016). Fuller-Thomson et al. (2016) found in a cross-sectional study of adults over the age of 18 that ACEs were associated with mood disorders like depression and anxiety, substance misuse, chronic pain like rheumatoid arthritis, and suicidality. In their systematic review of the literature, Larkin and Read (2008) reviewed the evidence that childhood trauma can also be associated with eating disorders, irritable bowel syndrome, autoimmune disorders, and memory, sexual, or aggressive difficulties as the trauma survivor ages.

In reviewing the influence of ACEs in older Japanese adults, Amemiya et al. (2018) suggest that polyvictimization is related to an increase in functional limitations as compared to those who had not experienced any adverse experiences during childhood. These functional limitations included decreased ability for self-care (such as meal preparation, bill paying, etc.), intellectual activities like reading newspapers, and social functioning (i.e., visiting with friends, or having conversations with younger people). In a different study, polyvictimization (including sexual abuse) was associated with the highest rate of internalizing disorders (i.e., depression, anxiety, PTSD, etc.; Rapsey et al., 2017). It is possible that internalizing disorders (as results of trauma) might play a large role in the functional limitations of trauma survivors, in that survivors of CSA tend to avoid social situations due to social anxiety and other psychopathology (Amado et al., 2015; Feerick & Snow, 2005; Pérez-Fuentes et al., 2013) Depression and anxiety are highly associated with increased difficulty in functioning in a myriad of ways (Kupferberg et al., 2016).

Thompson et al. (2015) discuss the known links between childhood trauma and a variety of health-related issues throughout life, and provide evidence that adults who reported having

ACEs have increased medical care needs. Kajeepte et al., (2015) found that sleep disorders like sleep apnea, sleep paralysis, nightmares, and narcolepsy are associated with ACEs as well.

Merrick et al. (2017) furthers this connection by noting the influence of childhood trauma on adult mental health, including an association between ACEs and substance use and depressive symptoms, and an increase in the likeliness to attempt suicide (Merrick et al., 2017). Crandall et al. (2019) explains that resilience despite ACEs may be related to ‘counter-ACEs’, which are beneficial or positive childhood experiences. With research suggesting that four or more ACEs lead to extraordinarily negative outcomes (such as suicide and early morbidity), counter-ACEs (such as positive relationships and social functioning) are thought to reduce the effects of the ‘four or more’ phenomenon on mental health and may be related to resilience in adulthood (Crandall et al., 2019).

### **Gender, Childhood Sexual Abuse, and Long Term Impacts**

Research examining gender and child sexual abuse suggests that gender plays a role in the frequency and types of abuse experienced and the long term impacts. For example, female children are substantially more likely to experience child sexual abuse than male children. Townsend and Rheingold’s (2013) meta-analysis found prevalence rates of 10.7–17.4% among females and 3.8–4.6% among males. There are gender differences in nature of the experiences too- women are more likely to have a sexual encounter prior to age 12 (11% vs 8.7%), while men are more likely to have severe contact at a young age (3.56% among women and 5.13% among men) (Das & Otis, 2016).

Both males and females who experience childhood sexual abuse may experience both sexual and/or psychological problems in later life, but research suggests that those effects may differ. Das and Otis (2016) used data from the 2010 to 2011 wave of the National Social Life,

Health, and Aging Project to explore the connections between childhood sexual abuse and outcomes in later life. They found a definite linkage between childhood sexual abuse and re-victimization for women, but results for men were inconclusive (Das & Otis, 2016). Steine et al (2017) used the Longitudinal Investigation of Sexual Abuse to examine symptom outcomes, social support, and hardiness in a mostly female (95%) sample. They found a significant dose-response relation between cumulative childhood maltreatment and PTSD symptoms, anxiety, depression, eating disorders, dissociation, insomnia, nightmares, pain, relationship behaviors and self-harm (Steine et al., 2017). They also found an inverse association between child sexual abuse and perceived social support.

### **Resilience and Trauma Symptoms in Late Life**

Perna et al. (2012) defines resilience as a form of stress-resistance that demonstrates overall psychological health. Individuals who have it adapt effectively to a variety of adverse experiences and circumstances. In this way, resilience is thought to be multi-dimensional and dynamic (Perna et al., 2012). Lamond et al. (2009) examined resilience in older adult women living in community settings. This study found factors such as personal self-control, ability to adapt and tolerate negative experiences, trust in a sense of intuition, and coping skills related to spirituality to be related to higher ratings of resilience with this population. Fontes and Neri (2015) implied that protective factors (such as coping skills, the ability to regulate emotions, etc.) function as forms of resilience for older adults. These protective factors are associated with greater quality of life in late adulthood and may explain differences in trauma symptoms in later life, yet little research is available on trauma symptoms and how they present in female older adults.

Trauma symptoms present differently in each individual and depend on factors including severity and duration of the trauma itself (Sadavoy, 1997). Traumatic symptoms can also improve or change based on the passage of time and positive or healing life events (Sadavoy, 1997). In their systematic review of PTSD from various types of trauma, Böttche et al. (2012) found people who suffer early-life trauma experience a decline in symptoms with the progression of age. While their findings suggest that trauma symptoms decline over time, Rapsey et al. (2017) had a different finding, that CSA was related to an increased risk of symptoms of anxiety, depression, and/or PTSD in older age.

Some researchers describe resilience as the absence of reoccurring symptoms in those who had experienced trauma. For instance, Chaudieu et al. (2011) examined the influence of PTSD and other trauma symptoms on mental and physical health in older adults. The results suggested that individuals who experienced trauma (but did not have recurring symptoms) were less likely to have mental health diagnoses than those with reoccurring symptoms. Chaudieu et al. (2011) described those without reoccurring symptoms, or those who had experienced trauma but had not developed PTSD, to be resilient.

### **Aim of this Study**

The aim of this study was to compare the severity of trauma symptoms of female CSA survivors across each decade, beginning with ages 18 – 29, and then assessing each successive decade. The *a priori* hypothesis was that the symptoms would be worse as age increased. While much research uses age 65+ to define older adults, we used 50+ due to literature that suggests that those who experience adversity may exhibit aging related symptoms earlier in life (Padgett et al., 2020; Simons et al., 2019).

### **Methods**



This retrospective study anonymously asked adult survivors of child sexual abuse (N=223) to discuss their abuse history and trauma symptoms in an online format via SurveyMonkey. The first author obtained approval from the University's Institutional Review Board (IRB Approval # 00003128). Then, information about the online study was sent to the webmasters of websites that are dedicated to the discussion and support of survivors of child sexual abuse. If the webmaster agreed to post the link to the study on their website, the link was sent to them. Potential participants clicked on the link in those websites to access the study. In order to be a part of the study, potential participants first had to click 'yes' to an informed consent online and then had to answer a series of inclusion/exclusion criteria questions. These questions ascertained the following information: 1) Is the respondent over the age of 18? 2) Is the respondent a survivor of child sexual abuse? 3) Has the respondent had any suicidal ideation in the last six months? 4) Has the respondent been hospitalized for emotional reasons in the last six months? 5) Does the respondent reside in the United States? This last question was included because support resources provided by the study (such as national hotlines) were specific to the United States, and if the participant became upset during/after participation, they needed to be able to access these resources.

Because of the sensitive nature of the survey topic, care was taken to conduct the study using trauma-informed methods. This study asked extensive questions about the nature of the child sexual abuse experienced by the participants in the study. As such, the methodology was formed in a trauma-informed way. First, the study was conducted online and was completely anonymous. DiLillo and colleagues (2006) advise that this methodology is preferred by survivors of trauma, as it does not require a survivor of trauma to disclose personal abuse facts in person to a researcher who will connect their face and name to their personhood and trauma history.

Second, the inclusion criteria protected potential participants by excluding those who were already emotionally overwhelmed (i.e., suicidal or had been recently hospitalized). Third, the resources (such as support groups and hotlines) were shown periodically throughout the study, and fourth, there was a reminder throughout the study that participants had the ability to opt-out at any point.

### **Sample**

Four hundred sixty-four people attempted to complete the survey. Two people were excluded for being under the age of 18, and sixteen potential participants were excluded because they were not CSA survivors. Twenty-one potential participants were excluded due to suicide attempts or mental health hospitalizations in the past six months. Seventy-two potential participants were excluded from the study because they did not reside in the United States (U.S.), because the resources attached to the study (such as the national suicide hotline numbers) were based in the U.S.

The original study was aimed at examining both males and females. Unfortunately, due to the low numbers of males in the original study, we focused our analyses on only the females in this study of older adults. All participants (N=223 female older adults) self-selected into the study and were all survivors of CSA. The majority of the sample was comprised of white females (84%). Over half of the sample (54%) had a college degree. Participants ranged in age from 18 to 72, with 17% of them aged between 50 and 59 (n=38), and 9% over the age of 60 (n=20). The total n for those participants who were 50+ was 58, which was 26% of the study's participants. We used age 50+ for female older adults due to literature that suggests that those who experience adversity may exhibit aging related symptoms earlier in life (Padgett et al., 2020; Simons et al., 2019). Age was grouped into deciles, with the exception of the highest grouping which went

from age 60-72. In our analysis we looked at both all respondents 50 + and the subgroups 50-59 and 60+ to make sure we did not miss any cohort based differences that might be masked by only looking at all female older adults.

## Measures

The *Child Sexual Abuse (CSA) Subscale of the Computer Assisted Maltreatment Inventory (CAMI)* is a retrospective instrument that uses 38 yes/no and Likert-scaled questions to measure childhood sexual abuse experiences for the first three perpetrators, (DiLillo et al., 2010). This instrument measures duration, frequency, and severity of CSA experiences. In the original psychometrics study that examined this measure, the test-retest reliability ranged from .65 to 1.00 and showed strong criterion validity (DiLillo et al., 2010). In the current study, this measure's reliability had a Cronbach alpha of .935, and was used to assess whether the participants were survivors of child sexual abuse.

The *Trauma Symptom Checklist-40 (TSC-40)* is a 40-item Likert-scaled self-report measure used to assess for current trauma symptoms in adults, and has six subscales: Anxiety, Depression, Dissociation, Sexual Abuse Trauma Index (SATI), Sexual Problems, and Sleep Disturbance (Elliott & Briere, 1992). Each subscale can be used on its own, or all of them can be used in combination to create a composite trauma score, as was done in this study. The *TSC-40* measures trauma symptoms on a continuous scale from 'never' experiencing a particular trauma symptom to 'often' experiencing that particular trauma symptom, such that someone who experiences anxiety 'often' is considered to have more severe anxiety than someone who 'never' experiences it. This measure has been psychometrically examined many times, and has always shown good, predictive, criterion, and convergent validity, as well as reliability (for instance, see

Elliott & Briere, 1992; Zlotnick et al., 1996). In the current study, the Cronbach Alpha for this measure was .944.

### **Data Analytic Strategy**

ANOVAs were performed to examine the presence of trauma symptoms in each age group. In order to avoid a Type I error, the significance level was decreased to .01 instead of the usual .05. Tukey post hoc tests were executed to examine the differences between age groupings while holding the error rate constant. Missing data was handled in two ways: 1) Data from open-ended questions was examined, and if that data held the answer to a quantitative question, it was input by the researcher. For instance, if age at time of abuse was left blank, but in a response to an open-ended question, the respondent said “When I was 5 years old, I was sexually abused by my stepfather, and...”, then the researcher input that age manually into the quantitative field. 2) All other missing data was excluded from analysis.

### **Results**

In every tested independent variable, the mean trauma score was lowest in the oldest age grouping (participants who were 60 and over), and highest for the youngest age group (those between 18 and 29, with the exception of dissociation in this age grouping; see Table 2 below). Moreover, in every tested independent variable except for sleep problems, the relationship between age and trauma symptoms was significant for the oldest group, as compared to all other age groups tested in this study.

As noted in Table 1 below, the relationship between the age variables and the trauma symptom severity variable was inversely proportional in that the trauma symptom severity scores of the participants in this study (with the notable exception of sleep problems) were lower in older participants, and the adults who were 60 years of age or over showed significantly fewer

trauma symptoms than the youngest age group. In terms of anxiety and total trauma symptoms, not only did the oldest age group show fewer trauma symptoms, so did the group of survivors who were 50 – 59 years old. In every variable except for sleep issues and dissociation, the oldest group experienced significantly less trauma symptoms than the youngest group, and in the case of sexual abuse trauma as well as sexual problems, the oldest group experienced significantly less trauma symptoms than all other age groups (except for 50 – 59 year olds). Furthermore, in terms of anxiety and total trauma symptoms, those in the 50 – 59 year old age group experienced significantly less trauma symptoms than the youngest age group. These results suggest that in terms of groupings, female older adults in this study experienced fewer trauma symptoms overall than younger female adults, and while there are no significant changes between the middle ages and younger/older ages, there is a definitive linear trend downwards with each passing decade with the highest trauma symptoms in the youngest participants and the lowest trauma symptoms in the oldest participants.

INSERT TABLE 1 HERE

## **Discussion**

CSA survivors are often considered ‘marked for life’, or that the effects of CSA are traumatizing for the rest of the survivor’s life, but this research suggests that may not be true. While CSA can be incredibly damaging and can lead to many terrible consequences (as has been shown in much of the literature; see Putnam, 2003 for review), this study’s results suggest that the effects of CSA may be lower in older populations. This is not to detract from the very real issues that face survivors of CSA; instead, these results should be interpreted as a way of

construing hope for survivors who are female older adults. While this research cannot explain why older adult survivors experienced less severe trauma symptoms, these results are encouraging, and can give both providers and older adult survivors a sense of optimism.

In terms of implications for treatment, late life is often considered a period of decline, and many of our aging services and approaches to care come from a declinist perspective. Findings that suggest improvement over time would shift that focus. Perhaps these findings would be best viewed from a resiliency perspective, in that all participants had survived child sexual abuse, but with benefit of age were able to achieve significantly lower trauma symptom severity scores. This finding speaks to the core of resiliency, which is the ability to thrive despite overwhelming obstacles (Domhardt et al., 2015). Obviously, this study cannot show causality (in that our study cannot suggest that the mere fact of aging causes a decrease in trauma symptom severity), nor should the findings be interpreted in this way. Instead, this study's results show that as the participants' age groups increased, the psychological symptoms decreased. These results are supported by earlier studies that suggest that the highest age groups studied have the lowest PTSD symptoms (Ditlevsen & Elklit, 2010).

Wiley et al. (2011) studied the post-trauma symptoms of survivors of Hurricane Katrina, and the authors took a very interesting Eriksonian approach in their explanation of the results of their study. They stated that in terms of Erickson's lifespan theory, their "findings suggest that identity distress may not be as salient of an issue for older adults (i.e., a negative correlation with age)" (p. 189), especially for those who do not experience post-traumatic stress. This interpretation might be applicable here as well, in that it uses Life Span Theory to understand these results as an epigenesis of life stages as we age (Erikson, 1950; Smith-Osborne, 2007), with each age grouping wrestling with age appropriate 'crises' and resolving them before

moving on to the next life stage. Once someone has resolved their identity crisis, they move on to Erikson's final developmental task of integrity vs despair, which involves life review and making peace with events that have occurred.

One important question that arises from this study is the question of 'why'. Why do trauma symptoms appear to get better with age? A cross sectional study such as this one does not allow us to draw these conclusions as there could be a myriad of reasons (such as trauma therapy at some point in life, the natural building of resilience through growth experience and aging, counter-ACEs, etc.). But this study's findings that suggest that trauma symptoms are lower in later life than in younger life and suggests more work in this area is needed to confirm this growth longitudinally and explore causal factors.

### **Implications for Clinicians**

The authors would like to suggest an important caveat for clinical practice: The results of this study do not show that female older adult CSA survivors do not have trauma symptoms. Instead, the results suggest that for the women in this study, the symptom severity (which in this case was measured by frequency of symptom occurrence) was lessened with each passing decade. Older adult survivors of CSA who have trauma symptoms or PTSD would not be comforted by the fact that the female older adults in our study had fewer trauma symptoms than younger CSA survivors, precisely because the female older adults with PTSD are still suffering. An older person's mean score on a trauma symptom scale should be treated for its own clinical significance. This is especially salient because survivors generally feel unentitled to their own symptoms of trauma (Mert et al., 2016). There is a maxim in the helping professions that we shouldn't compare pain, because pain is pain, and the authors would liken this phenomenon to trying to answer the question of which hurts worse: the loss of a leg or the loss of an arm. Both

pains are real and hurt, and to compare them would be absurd. It is the same when trying to compare levels of suffering for two people who have trauma symptoms. In a clinical setting, trauma symptom scale scores should be used to develop an individual treatment plan based on that person's unique experience.

With that caveat in mind, the results of this study are very hopeful, because they suggest that something is happening that causes female older adults to have lower levels of trauma symptoms. However, it remains unclear as to whether this is a generational affect or a healing mechanism, and this is where further research is needed. Future research needs to examine the known sources of healing (such as therapy and social supports) by age group, and also examine unknown sources by qualitatively asking such survivors "What has helped you heal from the trauma of child sexual abuse?"

### **Limitations and Future Research**

The findings of this study (and past studies) support the need to conduct further research on long term outcomes in survivors of child sexual abuse, particularly female survivors, as the previous research demonstrates linkages to a greater array of adverse outcomes than in male survivors. Additionally, there are greater numbers of female survivors in need of support due to the greater prevalence of victimization. One of the limitations of this study is that the reasons for the lower level of trauma symptoms in older respondents are unknown. Another limitation to this study is the fact that the majority of the participants were white women, and about half of our study's participants were college educated (or more), so these findings should be considered in a more diverse population. The number of non-white participants in our study reduced the scope of analysis we were able to perform, because there was an insufficient number of participants with ethnic identities other than white to analyze the interaction of ethnicity, age, and trauma. Future



research also needs to explore these questions longitudinally to better understand how these symptoms develop and change over time, and to explore factors that facilitate and threaten recovery.

Further research also needs to investigate how these effects hold up through the late life period. Even though our older adult participants (aged 60+) appear to be doing better, a more thorough investigation is needed to understand how these changes are weathered as individuals experience the trauma/challenges that may come in late life such as loss of a spouse, serious illness, or immobility. Does this earlier trauma make them more resilient than their peers or does this improvement break down as they lose coping mechanisms? One change that may occur is cognitive loss through the development of age-related dementias. While some work with veteran populations has begun to explore the relationships between PTSD and dementia (Mawanda et al., 2017), much more work is needed in this area to understand the impacts of childhood experiences and childhood sexual abuse on the development of dementia and how it is experienced within dementia.

Another limitation to this study was the exclusion of those with suicidal ideation, and those who had been hospitalized for mental health issues in the past six months. It is possible that this exclusion criteria may have introduced a bias into the study. There may have been more female older adults excluded by this criterion and thus may have skewed the results of the study. However, as the numbers were so clearly decreasing by age group for each trauma symptom measured, the researchers do not believe this to be the case.

Ultimately, this work is hopeful. If survivors of childhood sexual abuse do experience fewer negative symptoms in late life, this is a positive finding for growth and healing. We need

to find ways to enhance this healing, determine the influencing factors, and to support survivors wherever they are on their journey.

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## Appendices

**Table 1***FEMALES: Age and Trauma Symptoms (ANOVAs) N=223*

Independent Variables	N	M	SD	F	df	Sig.	Effect Size ( $\eta^2$ )
Anxiety							
18-29	27	12.56	5.33	4.97	4	.001 <sup>+ab</sup>	.0835
30-39	68	10.65	5.44				
40-49	70	10.04	4.81				
50-59	38	8.42	5.12				
60+	20	6.80	3.64				
Depression							
18-29	27	15.37	6.18	2.30	4	.060 <sup>a</sup>	.405
30-39	68	13.59	5.91				
40-49	70	12.96	5.88				
50-59	38	12.71	2.08				
60+	20	10.45	4.89				
Sexual Abuse Trauma							
18-29	27	11.56	5.65	4.21	4	.003 <sup>**c</sup>	.072
30-39	68	10.47	5.35				
40-49	70	9.70	5.39				
50-59	38	8.53	4.85				
60+	20	6.05	3.33				
Sleep Problems							
18-29	27	12.59	4.85	1.53	4	.194	.027
30-39	68	11.56	4.98				
40-49	70	11.67	4.75				
50-59	38	11.26	4.22				
60+	20	9.30	3.66				
Sex Problems							
18-29	27	11.19	6.22	5.24	4	.000 <sup>+c</sup>	.0877
30-39	68	10.97	5.72				
40-49	70	9.54	5.66				
50-59	38	8.03	5.15				
60+	20	5.35	4.46				
Dissociation							
18-29	27	10.00	4.73	2.37	4	0.054	.0412
30-39	68	8.96	7.82				
40-49	70	8.64	4.69				
50-59	38	7.63	4.65				

60+	20	6.25	3.85				
Total Trauma Symptoms							
18-29	25	63.52	23.86	2.92	4	.023* <sup>b</sup>	.0623
30-39	58	57.81	22.99				
40-49	58	53.84	22.22				
50-59	29	46.17	22.93				
60+	11	43.91	16.29				

\* Significant at the .05 level

\*\* Significant at the .01 level

+ Significant at the .001 level

<sup>a</sup> Significant difference between oldest age group and youngest age group

<sup>b</sup> Significant difference between 50 - 59 year olds and youngest age group

<sup>c</sup> Significant difference between oldest age group and all other age groups except 50 - 59