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Resilience to Trauma throughout the Lifespan: Overcoming Child Sexual Abuse

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by

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DISSERTATION

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Abstract

This qualitative dissertation project explored how young-old adults have healed from the traumatic experience of being sexually abused in childhood. This project utilized an Interpretative Phenomenological Analysis (IPA) to analyze themes across the young-old adults' responses. Data collection consisted of interviewing six participants (age 51-58) who have had a history of child sexual abuse (CSA) from a loved one or other trusted individual and have felt that they have healed and demonstrated resiliency from the experience. Ten general themes emerged: (a) Getting older has helped me develop a better understanding and helped me to become less emotionally reactive; (b) After the abuse, I went through a period in which I felt unworthy and that I was at fault; (c) After the abuse, I went through a period where I was sexually active to fill a void; (d) It is difficult to make meaning out of something so terrible. (e) As a child, I didn't have anyone who was supportive after the abuse event; (f) As an adult, at least one primary relationship was essential in my healing; (g) Talking about my experience was important in my healing; (h) Finding out "I wasn't alone" was essential in my healing; (i) Helping others has been essential in my healing process; (j) I've experienced typical physical changes as a result of the aging process. Although all participants reported having no one to turn to for support as a child, each participant indicated that at least one primary relationship in adulthood was imperative in their healing. Additionally, each participant indicated that getting older had led them to greater understanding and helped them to become less reactive.

Keywords: child sexual abuse, young old adult, aging

Resilience to Trauma Throughout the Lifespan: Overcoming Child Sexual Abuse

Chapter 1: Statement of the Problem and Literature Review

Research in the area of child sexual abuse (CSA) has grown significantly over the past few decades. Recent statistics suggest that CSA is more prevalent than once thought. With the increase in empirical studies, it has been found that as many as 33% of all women have experienced some form of CSA (DiLillo, 2001). This statistic is alarming and warrants further investigation.

By the year 2030, older adults will account for 20% of the population (APA, 1998). With the emerging baby-boomer generation, the number of older women is expected to double in the next 40 years (Cook, Dinnen, & O'Donnell, 2011). This is the first time in history that this percentage of people will live into late stages of life. With this growing population, there is an increasing demand for clinical psychologists to gain expertise in working with these individuals. Additionally, older adults' response to childhood sexual trauma is a topic that is frequently ignored in the literature. The scant research that does exist demonstrates findings that suggest that the developmental challenges that older adults face enable them to re-experience the effects of CSA. Due to the cultural climate older adults were raised in, they may have little information or insight into the adverse effects of child sexual abuse. Additionally, the effects of trauma in older women may go unrecognized (Cook et al., 2011). Research shows that in the past the re-experiencing of CSA has often been misdiagnosed as dementia or severe mental illness (Allers, Benjack, & Allers, 1992), leading to inappropriate treatment planning. There has been a dearth of research in this area over the past 20 years, calling for further investigation in this area. Understanding the subjective experience of the CSA survivor who is embarking on the

developmental journey of aging can lead to more sophistication in this realm and increased psychological aid for the older adult population.

Older adulthood is often indicated as a time of reminiscence. As this life review period is characterized as a time of great introspection, older adults with a CSA history may experience retraumatization. Additionally, loss of social support, stability, declining health and subsequent increased contact with the medical system may all be potential factors in CSA retraumatization during the aging process (Gagnon & Hersen, 2000).

Older adults may also have experienced events in their lives that have led them to heal from the effects of CSA. Exploring these potential resiliency factors and how individuals heal may aide in clinicians' ability to treat and work with individuals who have not yet healed from the effects of CSA.

In terms of emotional functioning, older adults generally are viewed as more focused on maintaining a positive emotional stance, and even become better at regulating emotion (Knight, 2004). Thus, Gagnon and Hersen (2000) argue that difficulties in emotional and cognitive functioning are not the result of normal aging. They believe that these impairments may be due to unresolved childhood abuse. It is a common misconception that the majority of older adults struggle and become depressed as a result of the aging process (APA, 1998). Clinicians may misattribute an older adult patient's distress to the effects of normal aging, missing what is occurring in the bigger picture. Failure to adjust to normal aging is the exception rather than the rule. Inaccurate assessment will undoubtedly lead to inappropriate treatment. Thus, there is a need for research to focus on different factors that contribute to some older adults' experience of distress during the aging process. This research study examines how young-older adults (age

51-58) with a history of child sexual abuse (CSA) are affected by the aging process. Additionally, elements of healing and resiliency throughout the lifespan are explored.

Allers et al., (1992) stressed the need for further research on the impact of CSA on adults. Over 20 years later, a lack of research still exists in this area. Additionally, Cook et al. (2011) describe the need to assess how trauma interferes with women's ability to navigate typical cognitive and physical changes associated with the aging process. They also stress the need for healthcare providers to develop an awareness of the link between trauma and associated distress in older adults, as this population is rapidly increasing.

Aging Holocaust survivors are found to have higher levels of both state and trait anxiety. Additionally, those who believe they had unsatisfactory quality of care post-Holocaust display a lack of well-being in their sixties and seventies. A main factor in trauma recovery was the way children were received by society post-Holocaust. Specifically, older adults were less likely to suffer negative impacts related to the trauma if they were understood, contained, and respected by adults post-Holocaust. The external world did not always react favorably and empathically to Holocaust Survivors. This reaction from others combined with the fragile internal state contributes to older adults feeling victimized for having survived the Holocaust. This study called for a need in aftercare trauma to counteract the negative effects in older adulthood (van der Hal-van Raalte, Van IJzendoorn, Bakermans-Kranenburg, 2007) and has potential implications for the effect of how the world receives trauma survivors which can be used to aide in how we interact with individuals after a trauma.

This purpose of this dissertation was to narrow the gap in the research literature on older adults with a history of childhood sexual abuse. Specifically, we addressed CSA survivors' experiences of getting older and factors in healing throughout the lifespan. As this population is

one that is frequently ignored in the literature, evidence is lacking for best practice of care in working with these individuals. As the number of older adults is increasing dramatically, and research shows that CSA is more prevalent than once thought, this area is one that should not continue to be ignored. This research focused on individuals who believe they have demonstrated resiliency in overcoming the trauma of a history of repeated forced or coerced sexual behavior imposed by a family member or other trusted individual. Resiliency and healing factors were explored throughout the lifespan. CSA survivors' experiences of coping with the developmental challenges of older adulthood were also addressed.

Conceptual Framework

Erikson's (1994) developmental stage theory served as the theoretical framework informing this literature. Erikson characterizes old age as a time when adults are trying to make meaning out of their lives. Thus, this is often a period of great introspection and reminiscence. During this life review period, older adult CSA survivors may experience a vulnerability to unresolved CSA and, thus reopen "psychic wounds" (Gagnon & Hersen, 2000). For these individuals, the experience of reminiscing may not necessarily be healing (Gagnon & Hersen, 2000).

Formal reminiscence and life review therapy is a common treatment for older adult patients. This therapy may be dangerous for survivors as repressed memories, feelings, and thoughts may be brought to conscious awareness (Peters & Kaye, 2003). However, this is just one hypothesis. The experience of life review may actually be healing for older adult CSA survivors as it may provide them with an avenue for understanding and making meaning out of their experience. Further research in this area is necessary.

Erikson (1997) discusses how the process of aging is characterized by a physical and functional decline, no matter what the aging adult may try to do to halt this process. The individual experiences an inescapable loss of autonomy, independence, and control (Erikson, 1997). During this time, the individual begins to grieve for that which is lost such as intimacy, strength, productivity, and ability to make decisions. There is an increased awareness that the past is unalterable and the future is imminently ending (Walter, 1992). These significant losses of self may be reminiscent of childhood in which the individual was not able to do anything to prevent the abuse from happening. However, it may be a positive experience in which the individual was able to make sense of and heal from the abuse in childhood.

Chapter 2: Literature Review

Older Adult Literature

The definition of "older adult" varies throughout the literature (APA, 1998). This study was initially going to focus on adults aged 65 and older. However, due to barriers in the recruitment process, the current study focused on young-older adults, age 51-58.

As the number of older adults has been increasing rapidly, APA (1998) posits a need for clinicians to obtain more knowledge in working with older adult populations. This is the first time in history that this many adults have lived into the later stages of their lives so healthily and so productively. At the time of this writing (2013), the first wave of the "baby boomer" generation will have reached age 65. By the year 2030, 20% of the U.S. population will be 65 years or older (APA, 1998). Additionally, with the emerging baby boomer generation, the number of older women is expected to double in the next forty years (Cook et al., 2011). Not only are there more older adults, but the "oldest old" age group (over 85) is the most rapidly increasing age group (APA, 1998).

Psychologists must be attuned to the wide array of challenges older adults face, what is developmentally normative and what features may be signs of pathology, and have familiarity with the wide range of professional issues in aging (APA, 1998).

Older adults are a rather heterogeneous group that frequently live independently, yet maintain close connections with family, and have lower rates of diagnosable depression than younger adults. Most older adults are capable of coping successfully with the challenges of aging. Additionally, older adults demonstrate better life satisfaction than any other age group (APA, 1998). An absence of this ability to cope and life satisfaction should alert the clinician to assess for variables external to the normative aging process. For example, older adults may

develop difficulties related to developmental stressors or neuropathology. Additionally, older adulthood is a time of increased medical illness. Often, psychiatric disturbances are comorbid with medical conditions (APA, 1998).

Erikson (1994) characterizes old age as a time of life review and reminiscence, in which one strives to come to terms with one's life meaning. Although this is a normative developmental task of old age, CSA survivors have the potential to be at heightened vulnerability to re-experiencing symptoms associated with unresolved CSA. This may transform the life review process from a time of healing to a time of re-traumatization. Life review therapy is common treatment employed by gero-therapists. Clinicians should be prepared to handle the reemergence of PTSD symptoms such as avoidance, depression, anxiety, and hyper-arousal. Additionally, they should be aware of potential factors in the healing process to be able to aid in providing adequate therapy and support for these individuals.

Effects of CSA on Adults

Browne and Finkelhor (1986) provide a comprehensive review on the impact of CSA. They define CSA as any sexual behavior imposed on a child by a much older person whether, or not obvious coercion is involved. This study will specifically focus on sexual abuse that was repeatedly committed by a family member or other trusted individual (Browne & Finkelhor, 1986). Due to the culture of secrecy surrounding CSA, it is hard to determine exact prevalence rates. It has been approximated that one-fourth of all females and 15 % of all males have experienced some form of CSA. This is CSA as characterized by the respondent and includes intercourse, fondling, kissing, and/or photographing (Finkelhor, Hotaling, Lewis, & Smith, 1990).

The original documentation of psychological symptoms post-child sexual abuse was Freud's description of hysterical and conversion reactions in his patients (Lerman, 1986). The more updated research describes a wide span of psychological effects as well. CSA leads to short-term as well as long-term effects. Short-term effects include anxiety, fear, depression, hostility and anger, and inappropriate sexual behavior. Chronic depression, poor self-esteem, self-destructive behaviors, feeling isolated, helplessness, hopelessness, difficulties trusting others, and revictimization have all been identified as long-term effects of CSA in adult survivors. Increased suicidality, sexual dysfunction, substance abuse, and increased sexual behaviors have also been identified as long-term correlates of CSA (Gagnon & Hersen, 2000). Finkelhor (1988) reported that over 50% of adult survivors have normal functioning, and only 20% suffer from acute mental health difficulties.

Psychological/emotional difficulties. As of their review in 1986, Browne and Finkelhor found depression to be the most common symptom of CSA in adults. It has been found that adult CSA survivors are also more likely to be hospitalized for depression, most likely due to a high incidence of suicide attempts. Among other depressive symptoms are increased feelings of guilt, hopelessness, helplessness, and low self-esteem (Browne & Finkelhor, 1986).

CSA survivors are also prone to symptoms of anxiety including panic attacks, nightmares, and sleep disturbances (Browne & Finkelhor, 1986). Phobias, hyper-vigilance and hyper-arousal are also common responses (Browne & Finkelor, 1986).

Effects on interpersonal functioning. DiLillo (2001) describes the social adjustment difficulties that women with a CSA history face. He discusses that at the college-level their abilities as a student, in dating and in leisurely activities are adversely affected. Perhaps the greatest difficulty female CSA survivors face is their experience in romantic relationships. These

women are known to have a wide array of ambivalent feelings towards men, including mistrust, idealization, and hostility (Briere, 1996). They report greater overall levels of marital discord (Jehu, 1988) and in the past, have demonstrated higher rates of separation and divorce when compared to their non-sexually abused counterparts (Finkelhor et al., 1990). Overall, CSA survivors report lower levels of relationship satisfaction (DiLillo, 2001), difficulties in emotional expressiveness, communication and intimacy (DiLillo& Long, 1999). These difficulties in interpersonal trust and intimacy likely contribute to CSA survivors' difficulty and low satisfaction in relationships. Additionally, suspicion and insecurity are common (DiLillo, 2001). Furthermore, adult women are at greater risk of sexual or physical revictimization in intimate relationships (Messman & Long, 1996). As parents, women CSA survivors have demonstrated difficulty responding to their children, and at times remain emotionally and physically distant from their children (Browne & Finkelhor, 1986).

Effects on sexual behavior. CSA has been shown to be related to a variety of difficulties in sexual behavior. There are two general patterns in the research. Adult survivors have been found to engage in high-risk sexual behaviors such as increased frequency and number of sexual partners and lower use of contraceptives. On the other end of the spectrum are adult survivors who have diminished sexual satisfaction in relationships, including pain, diminished ability to orgasm, and difficulties in sexual arousal (Ferguson & Mullen, 1999).

Maladaptive behavior. It is not uncommon for women with a CSA history to use alcohol or drugs as a form of self-medication. This behavior often starts as a coping style to try to numb the painful memories of the abuse, but often spirals into a self-destructive cycle (Walker, 1994). Suicide and self-injurious acts, eating disorders, and aggressive behaviors have been identified as behaviors in adult CSA survivors (van der Kolk et al., 1991).

CSA Self-Disclosure

Disclosing CSA may provide relief and social support, but my also lead to increased distress (McNulty & Wardle, 1994). Thus, the use of disclosure likely has great impact on the CSA survivor's recovery. Research has shown that the use of disclosure provides greater weight in terms of recovery than the actual nature of the abuse (Jonzon & Linbald, 2004, 2005). CSA survivors report experiencing shame prior to disclosure, but feelings of anxiety and distress following disclosure (Bonanno et al., 2002) as they feel unable to put their experience into a coherent narrative (Donalek, 2001). The interpersonal context in which the disclosure arises has been demonstrated to be an imperative variable, as CSA survivors have been shown to be acutely aware of the recipients' response to their disclosure (Herman, 1992). In adulthood, disclosure can be viewed as an ongoing, dynamic meaning-making process (Wright, Crawford, & Sebastian, 2007).

CSA Resiliency Factors

As individuals who present for treatment following a traumatic event are often distressed, resiliency has been conceptualized as rare among trauma survivors. There are multiple and unexpected pathways to resilience. Bonanno (2005) argues that resilience is the most common response to potential trauma. This is true of adults who were exposed to highly disruptive events. Resilience is distinct from recovery in that those who demonstrate resiliency manage to keep functioning at normal levels despite an increase in subjective distress. Recovery or healing, require an increase in trauma-related symptomatology before returning to pre-trauma baseline. Resilience, a common response to trauma, is associated with positive emotions and generative experiences. Additionally, individuals who are resilient demonstrate adaptive flexibility to challenging situations (Bonanno, 2005).

Studies have shown that success in school, as well as positive peer relations, have been identified as protective factors to counteract the negative effects of sexual abuse, which also increases the likelihood that they will have positive outcomes in their lives. Additionally, women who have a positive adaptation to sexual abuse have a positive outlook on the future, including a sense of hopefulness (Edmond, Auslander, Elze, & Bowlander, 2006).

Lev-Wiesel (2000) reported that adult survivors are more likely to have increased life satisfaction if they attribute the cause of the abuse to the perpetrator as opposed to blaming themselves or the situation. Thus, the perception of the abuse determines how the CSA survivor is affected by the abuse (Lambie, 2002). Additionally, a supportive response from family following the disclosure of the abuse has a great impact on the adjustment of the CSA survivor (Conte & Schuerman, 1987).

Healing CSA

Some individuals not only cope with the effects of CSA, but also engage in a healing process that promotes growth and recovery (Koss & Hoffman, 2000). Positive outcomes have been found in individuals who take an active approach to coping by engaging in strategies to address the stressor directly (Brand & Alexander, 2003). Additionally, seeking social support and making meaning out of the abuse have been associated with positive outcomes (Walsh et al., 2010).

CSA survivors who feel that they have taken control of their life direction report alterations in self-perception and new perspectives on life as a result of healing from abuse. These new perceptions are also associated with acceptance from others, self-care and nurturing, liberation, belongingness, achievement, and connection. Healing is viewed as an intentional and constructive process (Draucker, Martsolf, Roller, Knapik, Ross, & Stidham, 2011).

Findings have shown that healing required (a) an understanding of the nature of the abuse, (b) why it happened (especially whether or not they were to blame), and (c) how it has affected their life in the past and currently. Having an understanding of these factors and making life changes based on their understanding aide the healing process (Draucker & Martsolf, 2008).

There are various factors that contribute to the movement through the healing process including receiving messages from others that the CSA was wrong, disclosing abuse to help others, ongoing support during difficult times, finding inner strength and resilience, and taking control of their lives (Draucker et al., 2011).

Older Adult And CSA Literature

Gagnon and Hersen (2000) suggested that the demands facing adults may serve as a focus away from early traumatic experiences, allowing survivors to function more normally during the life stages in which childrearing and work are emphasized as major roles. This hypothesis does not address the functioning of older adults who no longer have these major life roles to focus on.

Over 20 years ago, Allers et al. (1992) called for further research to determine the impact of unresolved CSA on adults aged 65 and older. Since their writing, little examination has been done in this area and their findings suggest a reason for further research. They found that residual effects of CSA are likely to appear as chronic depression and potential revictimization, and are often misdiagnosed as dementia or mental illness. They believed that the struggles older adults face in coping with unresolved CSA are exacerbated by the physiological changes of aging, loss of social support, roles, resources, and other variables that had at one time served to distract the CSA survivor from re-living the traumatic event (Allers et al., 1992).

Cook and O'Donnell (2005) discuss how little is known regarding older adults' experience of childhood trauma. They report that aging-related issues, developmental tasks, and

cohort effects may all affect the experience and expression of trauma-related distress in older individuals. Due to these unique characteristics, they argue for specifically-tailored assessment and treatment for older adults. They also discuss the limited attention given to adult trauma survivors in the literature. They discuss how the effects of trauma in older adults has been so widely unrecognized that some have labeled the effects of trauma "hidden variables" in older adults (Cook & O'Donnell, 2005).

Cook and O'Donnell (2005) report that some older adults are less likely to admit to an experience of trauma due to shame or fear or negative past experiences with self-disclosure. The cultural climate of this aging adult cohort was a stigmatization of mental illness, which could be contributing to difficulty disclosing traumatizing events. Additionally, self-reliance is valued. Males of this older adult generation may particularly perceive psychological distress as a sign of weakness. Additionally, women of the older adult generation are familiar with playing a subservient role, which could also prevent the disclosure of CSA. Older adults may also misattribute somatic complaints to medical concerns, seeking inappropriate treatment. These reasons may all lead to misdiagnosis and inappropriate treatment of older individuals with trauma (Cook & O'Donnell, 2005). Additionally, the act of self-disclosure can provide meaning-making and understanding to aid in the healing of the CSA survivor.

Cook and O'Donnell (2005) also discuss the potential for an increase in trauma symptomatology following major life events such as retirement, major illness, or widowhood. They stress the need for clinicians working with this population to assess for late-life stressors and how these affect trauma symptoms. They discuss how the initial presentation of PTSD is often less dramatic in older adults and disclosure of trauma symptoms increases after psychoeducation and normalization (Cook & O'Donnell, 2005).

Residual effects of trauma may go undiagnosed due to older adults' failure to recognize a link between psychological disturbances and early trauma and healthcare providers' inability to recognize early trauma. The combination of these factors leads to inaccurate treatment planning which has adverse effects on the recovery of these individuals (Cook et al., 2011).

The misdiagnosing and revictimization disrupts the older adult's ability to function independently (Allers et al., 1992). These researchers saw a need for an expansion of older adult assessment into the realms of CSA. Additionally, they argued for age-specific support services in agencies providing treatment to CSA survivors. They argued for further research to focus on clinical interventions for older adults with a history of CSA (Allers et al., 1992).

Gagnon and Hersen (2000) identified the age-restricted findings as a major limitation within the literature. In their article, they addressed how CSA impacts the cognitive, behavioral, and emotional functioning of older adults. In addition to finding that a loss of social support and the decline of physical health contribute to the unresolved CSA symptoms older adults experience, they also found that the developmental task of life review increases vulnerability to re-experiencing the traumatic event (Gagnon & Hersen, 2000).

Intervening with older adult survivors is complicated by their difficulty in linking their early sexual trauma with current psychological problems and their failure to initially disclose a history of past sexual abuse. Additionally, clinicians may fail to accurately assess for early trauma as being a relevant factor in conceptualization and subsequent treatment planning for older adults. It has been found that clinicians may inadvertently misattribute symptoms of depression and anxiety to be a function of the aging process as opposed to exacerbation of an already-established issue (Gagnon & Hersen, 2000). Gagnon and Hersen speculate that the

greater amount of time that has elapsed between the potential traumatizing event and presenting to therapy, the less likely the CSA will be taken into consideration as a stimulus of the distress.

Older women tend to delay disclosing early traumatic experiences to their therapists. One study found that although no women disclosed a trauma history during the initial intake evaluation, 85% revealed histories of abuse or domestic violence during the course of therapy. Potential rationale for lower rates of reported trauma and distress in older women include limited memory, acquisition of coping mechanisms over the lifespan, and resiliency of women who live longer (Cook et al., 2011).

Assessment of trauma and potential negative consequences are typically not included in intake processes in health care or mental health settings. To date, there are no randomized control trials testing the effectiveness of psychotherapeutic interventions to alleviate the distress associated with trauma in older women. Cook et al. (2011) suggested that life review may actually be effective in helping older adults process and cope with trauma-related memories. They state that even in light of autonomic-arousal in medically-compromised older clients, this intervention should not be ruled out. They recommend a specific-focus in working with older adults who have a history of trauma (Cook et al., 2011).

Not only do work, social engagement, and child-rearing provide a sense of meaning and purpose during emerging and middle-adulthood, a sense of accomplishment in these areas can enhance the individual's self-esteem, life direction, and fulfillment. Perhaps this attained feeling of accomplishment can also be healing. Take these factors away and add functional limitations and declining health, and the effects of unresolved CSA may be reawakened in the older adult survivor. Poor health is correlated with helplessness, hopelessness, increased interpersonal vulnerability and dependence, and increased awareness of imminent death. This increased

awareness leads to life review, which may also heighten a survivor's vulnerability to the residual effects of CSA (Gagnon & Hersen, 2000) or may be healing if done appropriately.

Peters and Kaye (2003) specifically address the topic of post-traumatic stress disorder in older adults living in nursing homes. As of their writing in 2003, they were chagrined by the lack of research on PTSD in older adult survivors of CSA (Peters & Kaye, 2003). Through their research, they found that the conditions in homes for older adults served to provoke an experience of re-traumatization from the past sexual abuse. They use an example of older women feeling as if they have no control over their bodies, feeling as though someone can intrude on their personal space at any time, and having to have strangers touch them. They posit that aging itself and the atmosphere of retirement homes may serve to reactivate symptoms related to CSA that may have been dormant (Peters & Kaye, 2003).

Peters and Kaye (2003) estimate that one in three older women are survivors of childhood sexual trauma. They speculated that for the majority of older adult CSA survivors that it is likely that the abuse was not an isolated event, but rather re-occurred throughout the course of their lifetime. They believed that the transition from independence to retirement home living may re-open old feelings, thoughts, and coping mechanisms associated with the CSA (Peters & Kaye, 2003).

Retirement home living leaves the elder adult feeling powerless over basic bodily needs and in need of caretaking. Entering a retirement home also leaves the individual open to feelings of loss of external safety, privacy, personal space, and mobility. Thus, feelings related to the CSA are likely to be revived, creating mistrust in the elder CSA survivor. Family hostility during the relocating process may also evoke feelings related to the traumatic experience. They may be

at increased risk of revictimization while being less able to employ successful defenses to cope with the trauma (Peters & Kaye, 2003).

Benign touching used by caretakers in retirement homes may facilitate intense somatic memories of the abuse. Perhaps even more influential in the re-experiencing of child sexual trauma is the feeling of a loss of choice. Any behavior that is perceived as coercive by the older adult may lead to the re-experiencing of the traumatic event. Additionally, the hierarchy within retirement homes may serve as a reproduction of the family structure in which the CSA occurred. Theoretically, this replication could potentially be triggering, inspiring feelings, thoughts, and somatic memories representative of the abuse (Peters & Kaye, 2003).

As CSA is most likely to occur by a father-figure or prominent role model in the child's life, the elder female survivor is likely to have endured repeated abuse by a previously beloved parent. Thus, she may be hyper-attuned to the real or imagined trust betrayals of caretakers (Peters & Kaye, 2003).

Peters and Kaye (2003) argue for the need of a comprehensive assessment that is sensitive to the early life experiences of these individuals. This assessment should assess for all traumatic experiences, including child sexual abuse. They also suggest more adequate training of staff in retirement homes to increase their knowledge and awareness of trauma symptomatology, family roles, negative views and coercive behaviors of staff, meaning of loss and privacy, and the transition itself from independence to assisted living. Additionally, long-term staff should work to foster older adults' feelings of mastery and control over their environment. This is essential as the loss of choice and control have been found to be the most critical components of the re-experiencing of the trauma (Peters & Kaye, 2003).

Peters and Kaye (2003) provide a direction for future research on older adult survivors of CSA. Among their suggestions those relevant to this study are analyzing the effects of CSA on women born in the 1920s and 1930s, how the meaning attached to early childhood trauma have changed over time, if the meaning-making effects different symptom profiles, prevalence of symptoms, and future treatment for use with this population (Peters & Kaye, 2003).

Cook et al. (2011) discuss the need for healthcare providers to develop an awareness of the link between trauma and distress symptoms in older adults as this population is rapidly increasing. Additionally, because older adults are less likely to report psychological symptoms, assessment measures incorporating somatic indicators in differentiating trauma and other mental health descriptions should be utilized. However, there is a lack of empirically validated assessment tools for use with older adults.

Older adults risk of further revictimization. CSA significantly increases the risk of subsequent sexual assault in childhood, adolescence, and adulthood (Peters & Kaye, 2003). It is likely that women who have been sexually abused in childhood are vulnerable to further abuse once in a retirement home setting.

Researchers in the field are becoming more aware of alarming prevalence of child sexual abuse. Although a wealth of literature has been conducted on the long-term effects of CSA once the individual reaches adulthood, more research needs to be accumulated on the lasting effects into older adulthood. The research that does exist seems to suggest that older adulthood serves as a period of retraumatization for CSA survivors. This period of retraumatization is attributed to the developmental stressors older adults face, including loss of roles, increased contact with the medical system, and the developmental tasks of life review.

Research Questions

As research in the area of CSA has primarily focused on children and adults, this study sought to explore how older adults with a CSA history have coped throughout the lifespan and are coping now that they are embarking on the aging process. Positive adaptations to child sexual abuse were explored. In order to better inform clinical practice, the purpose of this study was to contribute to the existing literature on older adult CSA survivors, exploring coping mechanisms and healing processes.

1. How has CSA impacted the participants' lives, in terms of psychological and physical health and in the choices they have made?
2. Did they seek support and talk about abusive events or did they keep it to themselves? 3.
3. If disclosed, did the recipient support them in their use of self-disclosure?
4. Do adult CSA survivors experience retraumatization during the aging process?
5. Are there specific resiliency factors (such as health, relationship, socioeconomic status) that serve to buffer adverse effects in old age?
6. Are there any aspects in their lives that they believe have been integral in the healing process (i.e. accomplishments, relationships, community involvement)?
7. Has the meaning attached to the childhood trauma changed over time?
8. How do they think the process of aging has affected their physical and psychological health?
9. If there has been an effect, what resources have they used, either internally or externally, to cope with these problems?
10. Does aging itself feel like a traumatic process or a healing process?

Chapter 3: Methods

This study utilized a qualitative approach to data collection and analysis. In-depth interviews were conducted using Interpretative Phenomenological Analysis (IPA; Smith & Osborn, 2003) to collect data on how young-older adult survivors of CSA experienced and made sense of the CSA and how they are now experiencing the aging process. Additionally, a paper and pencil measure (adapted from The Modern Maturity Sexuality Study, AARP, 1999) was administered to participants to address the more straightforward questions about past and current sexual functioning. See Appendix C for the list of questions that were administered via questionnaire. Young-older adult participants who have identified both having a child sexual abuse history and making a positive adaptation out of the experience, were encouraged to tell their story of healing through the lifespan, as well as how getting older has affected them, with a focus on both psychological and emotional change, and meaning-making. Using IPA, the researcher discovered parallel themes within the participants' narratives. The emphasis on IPA is on the participants' personal lived experiences (Smith & Osborn, 2003).

Characteristics and Rationale of Method

Research demonstrates that participation in research in which personal experiences with sexual violence are shared enhances participants' healing and well-being (Warner et al., 2012). Participants report knowledge of the importance of participating in research, even if it feels uncomfortable and difficult at the time. Individuals contribute to research in hopes that others will benefit from their experiences (Warner et al., 2012).

Interpretative Phenomenological Analysis (IPA) is an appropriate method of choice when conducting research with older adult survivors of CSA. IPA is concerned with the meaning participants' make of their social worlds and allows for the incorporation of physical, cognitive,

and affective experiences. Additionally, it is the job of the researcher to provide and gain understanding through empathy which is what this population needs. IPA recognizes that interpretation is both a subjective and reflective process. IPA is idiographic as it examines the unique lived experiences of each individual participant and then steps back to examine emerging themes across participants and their narratives. The role of the researcher is both collaborative and active by facilitating an open dialogue about the participant's subjective world (Smith & Osborn, 2003).

Interpretative Phenomenological Analysis (IPA)

The researcher started with the narrative of the participant and then looked for emerging themes. A primary concern of IPA is how participants make sense of their personal and social world. IPA combines an empathic hermeneutics with a questioning hermeneutics, which are both necessary when trying to obtain information from adult CSA survivors. According to Mertens (2009), the term understanding usefully captures the two aspects of interpretation-understanding in the sense of identifying or empathizing with and understanding as in trying to make sense of. Empathy was used in the context of the heavy material that participants were discussing.

Interviews were approximately one to one and a half hours and were digitally recorded. The researcher explored the narratives for themes.

Sampling and Selection

Cook and O'Donnell (2005) report that some older adults are less likely to admit to an experience of trauma due to shame, fear, or negative past experiences with self-disclosure. The original flyer called for participants age 65 or older who have had a repeated child sexual abuse history by a family member or otherwise trusted loved one. After months of silence, the criterion for participants was expanded to encompass adult females who are 50 or older. No one over the

age of 58 volunteered. There is some controversy in the literature as to when older adulthood technically begins. Some characterize "young-old" as age 60-69, while others characterize "young-old" as beginning at age 50 (Vaillant, 2003). For clarity and ease of readability, participants will be referred to as "middle-aged" adults throughout the remainder of this study.

I found the recruitment process to be quite difficult. Indicative of the social stigma and taboo nature regarding CSA, recruitment flyers for this study were often removed from public areas. When seeking approval to post flyers in businesses, individuals would respond with concern that this flyer was not in patrons' best interest or would appease the researcher and then fail to post the flyer or take it down after it had been posted. This occurred both in places where a wide array of individuals gather (e.g., grocery store) and in places that are presumably more liberal-minded (e.g., community colleges).

Six female participants (age 51-58) were sampled from an online forum (Craigslist), via flyers posted in the community, and using the snowball approach. Participation was completely voluntary. See Appendix A for a copy of the recruitment letter.

Ethical Considerations and Informed Consent

Participants were informed of the nature of the study and any potential benefits and harm that may result from participation in the study. Participants were informed that their participation is completely voluntary and that no consequences will be placed upon them or their services should they not want to participate. Participants were informed of their right to withdraw their participation at any time. Additionally, participants were also informed of their right to refuse to answer any questions that they were too distressing. None of the participants refused to answer any of the questions. Participants were informed that their name and any other identifying

information will not be attached to their data. See Appendix B for a copy of the informed consent.

Data, Data Collection Method, and Interview Questions

Data was collected via semi-structured interviews and one self-report measure. Smith, Larkin, and Flowers (2009) suggest that researchers develop 6-10 research questions and allow for possible prompts that will provide richer, more contextual detail. Interviews consisted of 10 questions and lasted approximately one to one and a half hours. The individual's narratives were digitally recorded, transcribed verbatim, and meticulously reviewed for underlying themes.

Interview questions. Research questions cannot be definitively established before the study begins (Mertens, 2009). Interviews were guided by the schedule rather than dictated by it. However, the following questions served as a tentative interview schedule:

1. How has the aging process has affected your psychological health?
2. What has been the hardest part of the aging process?
    a. What do you think is responsible for this difficulty?
    b. How does this compare with others that are in your age group?
3. Over the years, how has the abuse affected your psychological health?
        a. Do you believe the abuse has had any bearing on the choices you have made? If so, how?
        b. Has the abuse had any effect on your physical health?
4. Have you been able to make sense out of the abusive event?
5. Has the meaning you've attached to the abusive event changed for you over time?
6. How have you coped with the abuse?
        a. Did viewing the abuse in a certain way help?

b. Who have you turned to for support?

a. Was he or she supportive?

7. Were there events in your life that helped you do better with the experience of being sexually abused as a child?

a. Graduation? Marriage? Birth of a child? Friendships? Relationships?

8. Have you noticed any recent changes in your ability to manage tasks of daily living or in any other areas of functioning?
9. How has the aging process affected your physical health?
10. Do you feel bothered by any particular aspects of the aging process?

a. Increased contact with medical field?

b. Loss of autonomy?

c. Loss of loved ones?

Record keeping and audit trail. The researcher kept a notebook log to outline the thought sequence and interpretive analytic inferences to prevent subjectivity. The digital recordings supplemented the notebook and allowed for greater ease in interpreting the rationale of developed themes within participant's interviews.

Researcher relationship to participants and data. The researcher remained in an active role by trying to make sense of the participants' experiences. The researcher provided an empathic and supportive environment (Smith & Osborn, 2003).

Data Analysis Procedures

The following section offers data analysis procedures. The steps of data analysis are outlined. First, the digitally recorded interviews were transcribed into a written transcript.

Looking for themes in the first case. The transcript was read a number of times, and notes were taken on any interesting or significant content that the respondent said. The researcher paraphrased and made summary statements. The right-hand margin was used to document emerging theme titles. The entire transcript was used as data (Smith & Osborn, 2003).

Connecting the themes. The researcher listed emergent themes on a sheet of paper and looked for connections between them. Initially, themes were listed in chronological order. In the next stage, themes were clustered together. As the clustering of themes emerged, they were checked in the transcript to make sure the connections worked for what the respondent actually said.

Continuing the analysis with other cases. The analysis continued by incorporating the interviews of the other respondents. Transcript 2 was worked on without the use of the table of themes from transcript 1. This ensured that attention was not diverted from new issues emerging in the subsequent transcripts.

Writing up. The last step in the data analysis procedure is to write up a final statement which outlines the meanings inherent in the participants' experience. This stage is concerned with transforming themes into a narrative account. Each superordinate theme is discussed in my results and discussion section (Smith & Osborn, 2003).

Sample of data. The study used a homogeneous, small sample size. Smith and Osborn (2003) describe the strength of the IPA method as being in depth of newly acquired knowledge, rather than breadth. Smith and Osborn (2003) suggested five or six as a reasonable size for IPA. This study interviewed six young-older adults (ages 51-58) with a child sexual abuse history to explore healing processes and meaning-making throughout the lifespan, as well as the experience of getting older.

Chapter 4: Results

In this chapter, I review the data collected from middle-aged adults who experienced child sexual abuse by a loved one or other trusted individual. They were asked a series of questions (Appendix D) regarding coping, healing, and meaning-making throughout their life span following the abusive event. Additionally, questions were asked regarding their experience of the aging process and the effect of aging on their physical, sexual, and psychological health. Data was interpreted into general themes. The results section is organized into three sections (a) participants, (b) demographics, (c) general themes, and (d) sexual attitudes questionnaire.

Participants

Participants were recruited using convenience and snowball sampling approaches. Due to difficulties in the recruitment process, the age requirements were opened up from 65 and older to 50 and older. Once individuals participated, most of them reported feeling relief and were grateful to have an avenue to talk about their experiences. Participants appeared more comfortable and open during the in person interviews. During phone interviews, participants appeared slightly more guarded, but still provided the information necessary for the purpose of this study.

Demographics

Six female middle-age adults (age 51-58) were interviewed and asked 10 questions regarding coping, healing, meaning-making, the effects of CSA on their overall psychological and physical health, and the effects of aging on their psychological, sexual, and physical health. Interviews took place in participants' homes or over the phone.

General Themes

General themes are discussion points that were present in all or most (4 out of 6) of the older adults' responses. General themes were topics that were generated in response to questions, or in response to the interview as a whole. In several cases, responses were quite similar which aided in the interpretative process.

Ten general themes emerged: (a) Getting older has helped me develop a better understanding and helped me to become less reactive; (b) After the abuse, I went through a period in which I felt unworthy and that I was at fault; (c) After the abuse, I went through a period where I was sexually active to fill a void; (d) It is difficult to make meaning out of something so terrible; (e) As a child, I didn't have anyone who was supportive after the abuse event; (f) As an adult, at least one primary relationship was essential in my healing; (g) Talking about my experience was important in my healing; (h) Finding out "I wasn't alone" was essential in my healing; (i) Helping others has been essential in my healing process; and (j) I've experienced typical physical changes as a result of the aging process. Participants were randomly assigned a number, which is not necessarily reflective of the interview order.

Getting older has helped me develop a better understanding and helped me become less emotionally reactive. All participants reported that the process of getting older has led them to a greater understanding, both in terms of who they are and how the abuse has had effected them. Additionally, all participants reported feeling less reactive and more at peace with where they are in life. One participant identified feeling "more well-adjusted" than others in her age group. Another participant reported that as you get older you start to feel "more at home" with who you are. One reported that she felt that getting older has "improved her." Although there were variations within the participants' responses, they all experienced greater understanding as

a result of getting older. The following verbatim responses demonstrate the middle-aged adults' experiences of greater understanding with the aging process.

Participant 1:

> **"**I think I'm more well-adjusted than people my age because I kind of say, if this is the way it goes we'll roll with it…It's like you have to come to a certain point, where you say okay, I'm however old, and this is my situation, you know I don't dwell on it, I give myself only so much time, only so much. And then I almost put it in a box, I don't think about it… I guess like I just kind of came to terms with it as something that happened in my life and it's not happening anymore…I didn't realize until last year that I wasn't bad and evil."

Participant 2:

> "To be honest with you, getting older has helped a lot. As you age, you begin to seek out answers….this is hard…Some people are no longer on the planet, so it gives you more time to think. Also, I think that even though I am reactive still, I'm nowhere near as reactive as I was when I was a kid. I've gained skills."

Participant 3:

> "Yeah, I think as you age you feel more at home with who you are, more comfortable with who you are…The sexual stuff from when I was a kid, is kind of, not much of an issue. There's so many other issues that come up… the sexual abuse is just one of many experiences that someone will experience in their life. It's not the end all of all things."

Participant 4:

> "I think I'm getting better at it and understanding more and not being as reactive as I might have been in younger days…I've gained more confidence, I've become more open in relationships."

Participant 5:

> **"**I think getting older has improved me. That's the word I want to use. I think that as you get older, you realize some things aren't worth dwelling on, and some things aren't worth making a big deal out of---or you'll be miserable. So you make a conscious effort to move on….Those incidents are not what define me."

Participant 6:

> "In some ways it's very freeing. I understand more, take things less seriously, I enjoy things more. See patterns of behavior in myself and others….More amused. Yeah, life is good."

After the abuse, I went through a period in which I felt unworthy and that I was at fault. Five out of the six participants indicated that they felt both unworthy and that they were to blame for the CSA. Two indicated that the realization that it was not their fault was helpful in their healing process. Three of the participants framed the blame in the past tense, indicating that they no longer view themselves to blame for the CSA. The following are verbatim responses portraying feelings of self-blame and worthlessness after the CSA.

Participant 1:

> "This impacts your life because you think you're worthless…I felt intensely guilty about it**,** intensely guilty…I didn't realize that until last year. I always just thought I was bad and evil, and you know it was my fault, pretty much that's what I thought. And last year I

was thinking hey wait a minute, I was just a little girl. I think people have to learn that it's not their fault. The other person was sick. Once I realized it wasn't my fault, that really helped me."

Participant 2:

"I knew I shouldn't have gone, that's where I blamed myself."

Participant 4:

"Because I was thinking I was at fault…what's wrong with me, and now thinking what do I need to work on and really there's nothing wrong with me."

Participant 5:

"I went through a period of time late teenage, young adult when I felt not worthy or less than."

Participant 6:

"I would say for years and years and years, it was very difficult not to blame myself. Even though I could work with other people and be so clear about it not being their fault and helping people to re-conceptualize, in the dark of the night, it's not what I believed for me. But that's not where I am anymore. That's kind of nice."

I went through a period where I was sexually active to fill a void. Four of the six participants indicated that they went through a period during teenage/young adulthood in which they were sexually reactive. All four indicated an understanding of why they were sexually promiscuous. One indicated that she believed she was "trying to erase the memory." Another participant indicated that she was trying to fill a void. Below are the verbatim responses indicating a pattern of sexual reactivity.

Participant 1:

> "Then when I just turned 15, I had a boyfriend and he impregnated me and I obtained an abortion by falsifying my birth certificate….Then after that, my sister introduced me to a man, I was probably like 17 or 18, and he was like, 27, 28, and he was a drug dealer and umm he introduced me to cocaine, and pot. He was really unattractive. I wanted to break up with him, he stopped me. I was done, there were people my age I was interested in, but I could not get rid of this guy. But again, this impacts your life because you think you're worthless… It was very difficult for me. So I became a dancer. When I stopped going to school I had to stop. I didn't know what to do, I was going nuts. I substitute taught, then I got a job, it didn't go well, I was still on the party train. …Even when I was pregnant that didn't stop me from these destructive behaviors. I think that this is all rooted in these early experiences where I was abused and I just felt worse and worse about myself."

Participant 2:

> "Made me promiscuous in the beginning. I kept looking for attention. The guy said to me I thought you were a virgin. I didn't even know what that meant. I had to make sure I wasn't a virgin anymore."

Participant 3:

> "I kind of think that it caused me to be more sexually active, kind of acting out more to kind of erase the memory even though the memory wasn't there."

Participant 5:

”Well, I think umm, some of my teenage behavior, I was fairly wild, I slept around a fair amount in my senior year. And I think part of that was trying to fill that void that was created by the abuse.”

It’s difficult to make meaning out of something so terrible. All but one participant seemed baffled by the question “Have you found a way to make meaning or sense out of the abuse that happened to you as a child?” All five indicated either directly or indirectly that there is no way to make meaning out of an experience like that. The following are direct responses from four of the participants regarding the inability to make meaning out of the abuse experience.

Participant 1:

“Some people are sick perverts, and I just happened to meet up with them.”

Participant 2:

“I don’t really know if I ever made meaning out of it. When I found out that this person had done similar things to other girls, made a difference. But that was later on in life. I didn’t really make meaning…its hard making meaning, I needed a lot more attention than I got. More positive attention. I try not to blame that on anyone. It was what it was.”

Participant 3:

“Meaning, no… but I’ve had other experiences that have over-ridden what’s way in the past.”

Participant 5:

“No I don’t think so. I don’t think those things ever make sense.”

Participant 6:

“If there is a God what was I supposed to learn? If you look at the Hebrew bible, sins of the perpetrator, what happened to him and his father where this was okay? Because his

> wife was the oldest daughter of a man and woman…Church of latter day saints said I as a baby spirit that I chose the parents that I would live with, so I chose to be in an environment where I would be sexually abused, that's a little hard for me….I go into fundamentalist Christian… the creator never makes a mistake, so what am I supposed to learn? Am I supposed to remember that Jesus died on the cross for me?...There are a lot of twisted psyches. People got hurt. I don't know what happened to him. I certainly had choices along the way about how I would treat others."

As a child, I didn't have anyone who was supportive after the abuse event. All participants indicated that they felt that they did not have anyone to turn to after the sexual abuse experience. Either they told someone and he or she was not supportive, or they did not tell anyone for fear of the consequences. Five of the participants told someone who was unsupportive and one did not tell anyone out of fear of destruction of the family. The following are verbatim responses that demonstrate the participants' experience of lack of support after the CSA.

Participant 1:

> "They treated me different from the other children, but that was also when I was very young…. I was the target child in that family….My parents devalued me and the other kids picked up on that."

Participant 2:

> "I tried telling my parents, my older brother. He was in Japan at the time, he came home and freaked out and told my parents about it and my father blamed me. I told them probably a year later. They have a different concept of stuff like that. My father called me damaged goods**.**"

Participant 3:

> "But my sisters don't believe me. They both say the same thing, 'dad only tried to French kiss me one time, and I told him no you're not my boyfriend.' They said no and it worked, gosh, I wish someone had told me I could do that…. mostly I just kind of had to deal with it on my own. I went for a long time without counseling."

Participant 4:

> "I didn't tell my parents because I was worried that my father would react violently. Like, worried about ruining the family because my dad is going to go kill this guy. Then I think I forgot about it in high school until college. When I got to college I started having flashbacks and things like that. I don't think I ever told anyone until I was actually married."

Participant 5:

> "I don't talk to my mother about it cuz at this point there's nothing she could do and it would just cause her grief. I told my mother once when I was in the third grade, and I said "mom daddy tried to put his thing in me" and she said "we don't talk about those kind of things." And that was the end of that. We don't talk about those kind of things. It was a different time. So I knew let's not talk about these things, so I didn't…. I never told anybody until I was in high school. A teacher, I took a class in high school, it was called family living. She had a question box, so I asked a question, and I think that was the first time I said anything to anybody."

Participant 6:

> "I told my mother and discussed it between the two of us and decided that we weren't going to tell my father because it would kill him, because it was my father's father. So

> you know, it would never be bad enough to tell my father, because it would kill him. So you see the double bind there…First off, she didn't believe me. And it was interesting because I felt something break inside of me. Then the next day, she asked if he was still doing it. And I said 'yes' and she said 'I know.' That's when she said she'd been watching him. She said she'd been watching him since then and in addition he had been doing it to her for the past year. That's when we tried to figure out what to do about it. How to keep out of his way. How to manage the situation because we couldn't tell my dad because it would kill him. Then periodically, she would ask me…. 'is it bad enough?' Like I said before, it's never bad enough to kill your dad."

As an adult, at least one primary relationship was imperative in my healing.

Although all six participants indicated that they did not have any support as a child after the abuse events, all six indicated that at least one primary relationship in adulthood was crucial to their healing. Five indicated that a romantic relationship was healing (four of these indicated that it was a husband). One participant indicated that her relationship with her child was essential to her healing from the CSA. The following are verbatim excerpts regarding relationships that have been healing.

Participant 1:

> "I do have to say that when I was younger and the kids were young, when I was married, I had a steady boyfriend from before, and he would give me money for food, for bills, back then I smoked a lot and he was a dealer. It was a good sexual relationship, very good….To have someone that buys your kids' clothes, who buys you food, you're gonna do it. I wasn't doing it for the sexual part….We're still in touch, he told me he did all that for me because he wanted to, that really made me feel good. That he did it because he

wanted to… The one thing was having these boyfriends, and having someone take care of me**.** Boyfriends during my marriage, that was really good, such a relief."

Participant 2:

"Having a child saved my life**.** I didn't really want to live for a long time and then she gave me a reason to live. It's a terrible thing to put that on a person. "

Participant 3:

"My husband's always been here. We married in 1981. I don't think I would have ever started remembering anything if I hadn't felt safe… Until I married him, I didn't know if there was a man who would be faithful."

Participant 4:

"As I lived with my husband, I became more comfortable and trusting, and I felt more relaxed and trusting. Which I think allowed the actual enjoyment of sex to increase. It takes a while to be in a relationship in which you feel completely safe."

"Yes absolutely. I have a core group of friends now, and one of the things that's happened is I've gained more confidence, as I've got more open with people about different things that happened, I've become more open in relationships. I experienced that I wasn't rejected, that people responded in a way that was caring and confidence building so I felt more comfortable letting go."

Participant 5:

"My husband is very supportive and very kind and is the kind of person that didn't care anything about my past or anything I had done in my past he didn't care, that didn't matter to him. So that same perspective really helped me get beyond the abuse."

Participant 6:

> "My kids, husband, my cousins, close friends, boyfriends… every sexual relationship I ever had, even the one night stands, I told them. And they were all my friends. And they were all supportive….my first serious boyfriend when I was 22, certainly the man I've married."

Talking about my experience was essential in healing. Five of the participants indicated that the experience of talking about the CSA was imperative in their ability to heal. One indicated that talking to the researcher was a healing experience. Four indicated that they had sought therapy to have an outlet to talk about the experience. The following are verbatim transcripts describing the healing experience of talking about CSA.

Participant 1:

> "I'm free, I told somebody, I'm done. Thank you for giving me the opportunity**,** it was a heavy burden to carry all these years… It was so good to talk to you. I've never said all this to anyone. I hope I answered all the questions without digressing too much. I would say in a word "cathartic."

Participant 2:

> "I went to incest and rape survivor's group therapy, then to therapy on and off since I was 21. Since I was old enough to get my own therapist. Talking about it. I never had a problem after a certain age, I started talking about it…. Well, I do think in a lot of ways therapy helped. I think therapy helped a lot in that I remember the first person's reaction was "where's your anger?" And I was like I don't know why would I be angry? And thinking that through."

Participant 3:

> "I was in an incest group and that was in the mid 80s and I pretty much haven't talked about it since then….I believe in counseling. I convinced my sister to go to counseling not too long ago. And I wish my daughter would, but she won't. But I think talking about things, is…I don't like secrets, I'm not a secretive person."

Participant 4:

> "I have actively sought treatment, individual therapy, family therapy, marital therapy…I think "don't keep it a secret' you need to talk about it so you can get over it and move on. Get the help. Don't stay isolated forever."

Participant 6:

> "And uh, two good counselors, one in DC, one here…You know, I talked about it quite a lot… It helped unpack things and pack them back up…I remember back in the 80s when I would be reading about this stuff: 'given these statistics, it isn't that incest and CSA are taboo, its talking about it that's taboo.' Cuz it sure as hell happens all the time."

Finding out "I wasn't alone" was helpful in my healing. Four of the participants indicated that finding out that others had gone through similar experiences was helpful in their healing process. One indicated that even portrayals of CSA survivors in the media helped her realize that she was not on her own. The following are verbatim participant responses regarding the power in hearing others' experiences.

Participant 1:

> "Reading about people's experiences and how people are so tuned into that. And how there is so much stigma attached. I would watch Law and Order and the scenarios were

exactly the same. And the kids' reaction too. Then I thought maybe it wasn't me, and it wasn't me."

Participant 2:

"And meeting people with similar experiences… Yes. Very helpful. Because I think it's how you learn. For one thing, I blamed myself for years. Even though my therapist told me it wasn't my fault. I thought my body betrayed me, and seeing that other people felt the same way. It gave me room to say 'uuuuuh, okay.' That made a huge difference. That helped."

"I think I just wish that I had known that it was more common. The one thing I would hope is that people would know that they weren't alone."

Participant 4:

"It seems so obvious to me now…but when we were teenagers, we didn't talk about those kinds of things. The isolation keeps you from moving forward, and at least understanding and finding better things in your life."

Participant 6:

"Two of my cousins went through the same thing. Although I was the worst target so when we started talking that was good."

Helping others has been important in my healing process. Five of the participants described the experience of helping others to be important in their healing process. Four indicated that they chose generative professions in order to help others. One described a general feeling of needing to help others. The following are verbatim transcriptions regarding helping others.

Participant 1:

> "Because of the consistent abuse throughout my life, I want to be the good guy and I don't want to hurt other people."

Participant 2:

> "I'm a teacher and getting my Master's in Special Education. Well**,** I think this is an exercise in loving me**.** In my desire to help people, I'm helping myself."

Participant 3:

> "I'm studying Christian counseling… what I really want to do is provide services in my church setting without charging them…To give back, yeah. To give to others. I hate taking from people. I would do anything to prevent people from going through what I went through."

Participant 4:

> "For me, I personally feel that without it I would not be the person that I am and I would not have chose the work path, I would have done something differently. It directed me to what I do now, and I'm really okay with that. I like what I do, I'm good at what I do, I give back a lot. I work in mental health. I run a program for families with children with mental illness."

Participant 6:

> "In many ways I always thought that it led me to this profession cuz like many kids growing up in some kind of an abusive family, and who had been successful coming out of it, it's like I grew antennae. I knew what people were thinking, I knew what was upsetting them. I knew. And I suspect that's from years and years and years of having to be very aware of everything that was going on in order to stay safe…Working with adult

survivors, working with trauma survivors across the board. Working with people with depression and anxiety diagnoses, all of those gave me more insight doing things that I'd ask them to do."

I've experienced physical changes that are typical of the aging process. All participants indicated that the physical changes they have been experiencing are typical of the aging process. None of them believed that they had any physical changes as a result of the CSA. Two of them mentioned weight gain that they believed was typical of the aging process. Three mentioned aches and pains that they believe to be typical of the aging process. Below are their answers regarding physical changes with age.

Participant 1:

"I've lost some flexibility, I think that's because I haven't been working out as much, but I think that's normal too. Nope that's it. I've gained some weight."

Participant 2:

"I broke my neck about 5 years ago. I don't think its due to that, maybe indirectly, I have some arthritis in my back, when did that start? I noticed sitting really bothers me."

Participant 3:

"My sisters and brother are in such bad health. And I'm in such good health. There's always things happening to me, but I always seem to recover very well."

Participant 4:

"I think getting older, not being satisfied with the way I look and kind of being aware that I haven't worked that hard to keep myself looking as good as when I was younger, so I have to work harder to get there….. I have more weight than I had when I was younger and my knees hurt sometimes."

Participant 5:

> "I guess I'm considered healthy, but there are aches and pains. You know my back hurts much of the time. I have to take thyroid medication that started in my twenties. But other than that, I'm just getting older."

Participant 6:

> "The hardest part is my body is not where my mind is. It takes longer to recover from things, it takes longer to recover from, if I don't get a full night's sleep, it actually takes a while to get my feet back on the ground, if I go hiking it takes time to recover. If I lift weights it takes time to recover. So physically, the recovery period is so different."

Sexual Attitudes Questionnaire

1. Sexual activity is a critical part to a good relationship. Two participants answered that they "strongly agree" that sexual activity is critical to a good relationship. Three participants answered that they agree and one participant answered that she somewhat agrees. Thus, all participants agreed that sexual activity is critical to a good relationship.

2. Sexual activity is important to my overall quality of life. One participant answered that she strongly agreed that sexual activity is important to her overall quality of life. Three participants agreed with this statement and two participants "somewhat agreed" that sex is important to their overall quality of life. Thus, all participants agreed that sex is important to overall quality of life.

3. I do not particularly enjoy sex. One participant answered that she strongly disagreed with this statement. One participant answered that she somewhat agreed with this statement. Three participants answered that they disagreed with this statement. One participant answered that she somewhat disagreed. The data for this question are much more variable, indicating that

CSA survivors' enjoyment of sex is more differentiated than the attitudes they have regarding sexual activity. Cognitively, there is an awareness that sex is crucial, but they may not particularly enjoy the act.

4. How satisfied are you with your sex life? One participant answered that she was extremely satisfied with her sex life. One participant answered that she was satisfied with her sex life. One answered somewhat satisfied, one answered somewhat dissatisfied, and one answered dissatisfied. Thus, the satisfaction level of sexual lives ranges throughout participants.

Chapter 5: Discussion

In this chapter, I expand on the data presented in Chapter 4. The core themes found between participants' data are interpreted and discussed. The research questions we sought to answer are addressed, including (a) How do CSA survivors experience the process of getting older? (b) What effect did the sexual abuse have on the CSA survivor's psychological health and the choices they made? (c) Did they seek support and talk about the abusive events or did they keep it to themselves? (d) Are there relationships in CSA survivors' adult lives that are imperative in healing? (e) What other factors are imperative in healing from CSA? (f) Was there meaning attached or did viewing the abuse in a certain way help promote healing? (g) How has the aging process affected CSA survivors' physical health? Additionally, the study's limitations, future implications and general implications, and a conclusion are provided.

General Themes

How do CSA survivors experience the process of getting older? All six participants indicated that getting older has had a positive impact on their coping and ability to put areas of their lives into perspective. Throughout each response was a report of increased understanding and decreased emotional reactivity. As this is quite counter to the current research on trauma that focuses on aging as a period of retraumatization (Gagnon & Hersen, 2000, Peters & Kaye, 2003), these findings may be indicative of CSA survivors who experience themselves as resilient. It may be difficult to determine if these adults (age 51-58) will experience retraumatization once they ascend into the older adult (65 and above) category. However, all six of these participants indicated embarking on a trajectory that seemed to provide them with more insight and less emotional reactivity as the aging process continues. For example, one participant explicitly said "I think as you age you feel more at home with who you are, more comfortable with who you

are" (Participant 3). Another stated "I think I'm getting better at it and understanding more and not being as reactive as I might have been in younger days" (Participant 4). Participant 5 stated **"**I think getting older has improved me. That's the word I want to use. I think that as you get older, you realize some things aren't worth dwelling on, and some things aren't worth making a big deal out of-or you'll be miserable. Another participant said "In some ways it's very freeing. I understand more, take things less seriously, I enjoy things more" (Participant 6). This finding is consistent with the APA (1998) who stated that older adults tend to have lower rates of diagnosable depression and higher rates of life satisfaction. Knight (2004) reported that older adults generally are viewed as more focused on maintaining a positive emotional stance, and even become better at regulating emotion.

Findings from this study provides a hopeful outlook for those who have survived CSA. Although the participants interviewed in this study are slightly younger, this finding differs markedly from that found in the existing literature on older adult CSA survivors. As opposed to Peters and Kaye (2003) who found older adulthood to be a time to dread, this finding indicates that older adulthood can bring peace and comfort and that aging can actually serve to enhance quality of life.

What effect did the sexual abuse have on CSA survivors' psychological health and the choices they made? Five out of the six participants indicated that after the abusive experience, they felt that they were unworthy and to blame for the CSA. This finding is consistent with the literature on adult CSA survivors (Browne & Finkelor, 1986), which states that feelings of guilt and self-blame are typical for this population. Lev-Wiesel (2000) reported that adult survivors are more likely to have increased life satisfaction if they attribute the cause of the abuse to the perpetrator as opposed to blaming themselves or the situation. Thus, the

perception of the abuse determines how the CSA survivor is affected by the abuse (Lambie, 2002). The middle-aged adults interviewed no longer had the experience of self-blame and guilt. This finding indicates that these feelings are transient and are able to be worked through with the help of healing factors discussed in a subsequent section.

Four out of the six participants indicated that they went through a period in which they were sexually reactive to fil a void created by the abuse. This is consistent with the literature on CSA survivors, who have been found to engage in high-risk sexual behaviors such as increased frequency and number of sexual partners (Ferguson & Mullen, 1999). However, it seems that all participants who indicated sexual reactivity acknowledged this as a "period," one which had a definitive end point. Participants acknowledged the end point as being when they were able to get into an intimate romantic relationship in which they felt safe and secure.

Did they seek support and talk about abusive events or did they keep it to themselves? All participants indicated that they felt that they did not have anyone to turn to for support after the sexual abuse experience. Either they told someone and he or she was not supportive, or they did not tell anyone for fear of the consequences. Five of the participants told someone who was unsupportive and one did not tell anyone out of fear of destruction of the family. The one participant who did not tell anyone chose not to tell for fear of her father reacting violently toward the perpetrator. One participant indicated that she told her mother and her mother chose to hide it from the father, for fear that it would kill him. Two participants indicated that their mother did not believe them. One indicated that their mother explicitly told them not to talk about it. One participant's father called her "damaged goods" when he found out. This finding is important as Conte and Schuerman (1987) found that a supportive response from family following the disclosure of the abuse has a great impact on the adjustment of the

CSA survivor. While this may be true, it was not necessary for recovery for these middle-aged adult participants to have someone who was supportive at the time, as long as they had a healing relationship later in life.

Are there relationships in CSA survivors' adult lives that are imperative in healing? Despite an absence of support in childhood, each participant indicated that at least one primary relationship was healing in adulthood. Four indicated that their husband was a primary relationship that was imperative in healing, providing increased feelings of acceptance, trust, and safety in talking about their experiences. Similarly, one indicated that she had boyfriends that were essential in her healing because they helped her because they "wanted" to and she finally felt taken care of. One indicated that her relationship with her daughter gave her a reason to live, and two others indicated that children were essential in their healing. Relationships were a fundamental component of healing, without which participants did not believe that they would be functioning as well.

This finding also provides a hopeful outlook that contrasts with DiLillo's (2001) review in which it was found that CSA survivors report lower levels of relationship satisfaction, suspicion, and insecurity. Additionally, Briere (1996) indicated that CSA survivors have a wide array of ambivalence, mistrust, and hostility towards men. DiLillo and Long (1999) found that CSA survivors have difficulties in emotional expressiveness, communication, and intimacy. The degree to which these middle-aged adults were able to participate and in turn, feel healed by these safe relationships speaks to a different experience. These middle-aged adults were able to trust, experience feeling accepted and safe, and communicate to get their needs met.

What other factors are imperative in healing from CSA? In addition to having at least one corrective relational experience, participants indicated that talking about their abuse

experiences, finding out they were not alone, and feeling that they are able to help others in some way was essential in healing.

Four participants indicated that they had sought therapy to have an outlet to talk about and process their experience. One indicated that having someone to help them understand normative emotions was essential in healing. One participant indicated that talking with the researcher felt "cathartic," and that she had been carrying around a heavy burden all of these years and finally felt free. One indicated an awareness around the dangers of not disclosing the abuse and continuing to remain isolated. In terms of alleviating isolation, four participants indicated that finding out they were not alone was imperative in their healing process. Two indicated a general alleviation of isolation from meeting people with different experiences, one noted that portrayals in the media helped her understand that she was not alone, and one indicated that finding out that the perpetrator had done the same thing to others helped her realize she was not alone.

The usefulness of disclosing about the abuse experience is consistent with McNulty and Wardle's (1994) findings that discussing CSA may provide relief and social support. Additionally, research has demonstrated that the use of disclosure has provided greater weight in terms of recovery than the actual nature of the abuse (Jonzon & Linbald, 2005). It was not found in this study that self-disclosing led to greater distress (McNulty & Wardle, 1994).

Four participants embarked on generative professions, and were able to make a career out of helping others. This is consistent with Draucker et al. (2011) who reported that CSA survivors who feel that they have taken control of their life direction report alterations in self-perception and new perspectives on life as a result of healing from abuse. One participant is in the mental health field, and reported working directly with trauma survivors. She feels that she was drawn

to this profession as she had a certain sensitivity to others that she believed grew out of her experience of having to be constantly attuned to and aware of her experiences going on around her. In addition, two of the participants sought out the counseling field in order to give back to others, and one is a teacher and is getting her Masters in special education. Thus, going into professions in which one can help others and give back can be quite facilitative of the healing process.

Was there meaning attached or did viewing the abuse in a certain way help promote healing? Overall, CSA survivors did not believe that you could attach meaning or make sense out of such a terrible experience. Most participants seemed puzzled by the question, suggesting that the process of even thinking about making meaning out of the experience seemed absurd. Walsh, Fortier, and DiLillo (2010) found meaning-making to be useful to the healing process of CSA survivors.

It seems less about the meaning that was created by the experience of CSA, and more about shifting the blame from the self to the perpetrator, or in one participant's case, not wanting to blame anyone. Erikson (1994) characterizes old age as a time of life review and reminiscence, in which one strives to come to terms with one's life meaning. Although, it appears that even if adults did not make meaning out their abuse experience, that they are not negatively affected by it when going through the process of life review. Thus, life review is not a period of retraumatization for these individuals. They are simply able to acknowledge that it happened, that there are bad people out there, and that sometimes bad things happen to good people. Thus, they were able to extract themselves from the experience, as opposed to finding the experience meaningful in some way to their lives. This has important implications for therapists working with older adults who have a trauma history. With this small sample size of six, it seems it would

be harmful when engaging in life review therapy to place more emphasis on the abuse experience than the client or to falsely believe that the experience currently has more weight than it does. These individuals have been able to remove this experience from their identity and acknowledge that this experience does not define them.

As therapists, we have a tendency to believe that what the client is presenting with is important, but that there must be more to the story, more underlying, more underneath, more. When we do this, we may be making assumptions to fulfill our intellectual need for deepening of experience and meaning. It seems like we want to look at our clients with a raised eyebrow if they were to say something like "people are bad, and that's not about me anymore." We want to make those connections between past experiences and current functioning, but for our adult clients who believe that they have healed from the effects of CSA, doing so is likely to be unhelpful and unfruitful.

How has the aging process affected CSA survivors' physical health? According to the American Psychological Association (1998), psychologists must be attuned to the wide array of challenges that older adults face, what is developmentally normative, and what are signs of serious pathology. There was concern from Peters and Kaye (2003) that older adulthood would be a period of retraumatization, which would consist of emotional, as well as physical changes. These CSA survivors do not seem to differ from individuals within the same age group without a CSA history in terms of physical changes that occur during the aging process. All participants indicated physical alterations that are typical of the aging process, such as aches and pains, dissatisfaction with physical appearance, weight gain, and loss of flexibility. Not one participant believed that they had experienced physical changes as a result of the CSA at any point throughout the lifespan. The absence of physical changes may be another indication of resilience.

Has the abuse and the aging process had any impact on sexual functioning?

According to the brief questionnaire administered to participants, it appears middle-aged adult survivors of CSA experience normative age-related changes to their sexual functioning. All participants agreed that sexual activity is critical to a good relationship and important to overall quality of life. The data for enjoyment of sex and current sexual satisfaction were much more variable. CSA survivors' enjoyment of sex is more differentiated than the attitudes they have regarding sexual activity. Cognitively, there is an awareness that sex is crucial, but they may not particularly enjoy the act.

In the interview process, those that identified a hyper-sexual response to the abuse indicated that establishing comfort and trust in a consistent relationship helped them. Once they established meaningful interpersonal connections, they were no longer left searching for fulfillment of the void.

Study's Limitations

One major limitation of this study was the difficulty in recruiting older adults (65 and older) to participate and talk about their experience of healing from CSA. As consistent with the cultural climate of stigmatization among older adults regarding the discussion of CSA, not one adult over the age of 58 agreed to participate. This study interviewed individuals who were 51-58. It is difficult to determine if these middle-aged adults would experience aging in quite the same way 10 years from now. As Gagnon and Hersen (2000) indicate, retraumatization typically occurs via loss of roles, social support, and increased contact with the medical system. As the majority (5 out of 6) of these participants were still working or going to school, it is difficult to determine if they will be experiencing the positive effects they have experienced getting older once they no longer are as productive. Additionally, due to the inherent nature of Interpretative

Phenomenological Analysis (IPA), this study utilized a small sample size of six participants. The small sample size combined with the younger age group make it difficult to generalize to the overall older adult population.

Future Implications

Recruiting older adult participants who are willing to speak about their experiences was a major barrier in this study. Finding a way to break this barrier and engage older adults in qualitative research regarding their experience of trauma would likely be useful in providing a lens that does not currently exist in the literature. The current study provides some evidence to suggest that life does get better as survivors get older. Conducting interviews with individuals who are aged 65 or older would provide data to reinforce that old age is not experienced as retraumatization for CSA survivors.

Implications

This study provides a hopeful outlook for survivors of CSA. Hope is an expectation that recovery is possible (Yalom, 1995). Hope is important not only for CSA survivors, but for clinicians and supportive loved ones of trauma survivors. Yalom identifies the instillation of hope as a primary therapeutic factor in healing and moving forward. We as clinicians must be able to sit with our clients and believe that it will get better, while transmitting this belief into our clients. Hope offers the possibility that there is light through the tunnel, that we can start to feel better even in our darkest times. Direct quotes such as “as you age, you start to feel more at home with who you are (Participant 3) contrasts starkly with the belief that once existed in which after an individual experiences trauma, they more often than not are plagued with long-term, insufferable consequences. Although this particular participant quote suggests a natural

progression, it is clear that having some capacity for hope enabled these participants to engage in their lives in a way that allowed them to experience healing. This study found that self-disclosing, finding out they were not alone, and finding ways to be generative and helpful to others was essential to healing. As much pain and trauma an individual may sustain, they can find hope within themselves through establishing emotional connections with others.

At times, our clients are coming to us with their last ounce of hope. For clinicians, our instillation of hope is essential to help clients who may not be in a hopeful place. For loved ones of survivors, our hopefulness can serve as a guiding light where there may not otherwise be one. This study provides evidence that it does get better.

In considering how best to help individuals who have experienced trauma, it is best to hear straight from the survivors of trauma what they thought would have been helpful to them prior to recovery. The researcher asked participants at the end of the interview if they could tell others who have gone through similar experiences what they wished they had known, what they wished someone had said to them. Participant 2 stated "I think I just wish I had known it was more common…the one thing I wish is that people would know they weren't alone." Participant 3 stated "You'll get through it, but you can't tell anybody that. They have to find out for themselves…love is powerful and transformative." Participant 4 stated "don't keep it a secret, you need to talk about it so you can get over it and move on…Don't stay isolated forever. The isolation keeps you from moving forward, and at least understanding and finding better things in your life." Participant 6 simply stated "never give up." Thus, it feels less about the content of what we can impart to our loved ones and clients who are trauma survivors, but the process of instilling hope, helping them understand the universality of their experiences, and providing a space of love and acceptance.

This study leaves important implications for psychologists to be aware of. It only takes one supportive relationship to provide acceptance and understanding to help CSA survivors to feel that they have healed from CSA. This provides further evidence for just how important the therapeutic relationship can be. Although individuals in this study had developed relationships outside of therapy, sometimes clients are coming to us in a state of isolation, without the experience of trusting and feeling accepted.

Conclusion

All participants indicated increased understanding, less emotional reactivity, and overall improvement in their mental health as they have gotten older. This study sought to find an alternate perspective to the idea of old age as a period of retraumatization for those who have experienced CSA. Although the population studied was younger than that originally targeted, this study has important implications for how individuals with a trauma history experience getting older. Individuals in this study were comfortable with who they are generally, and who they are in relationships, and believed to have derived this comfort by getting older and gaining other experiences.

All individuals who participated in this study self-identified as resilient. Thus, it seems that the ability to distance oneself from the CSA event and develop greater understanding, less emotional reactivity, and more positive coping throughout the lifespan is related to resilience. Additionally, the ability to derive enjoyment out of the aging process and find comfort within oneself and with others appears to be correlated with resilience. Not one participant believed that they experienced any physical changes as a result of the CSA and believed that any physical changes they experienced were normative to the aging process. The absence of physical alterations in result to CSA may also be related to resiliency in CSA survivors.

Additionally, all participants indicated that when the abuse first happened as a child, they either did not tell anyone for fear of the consequences, or told someone and he or she was not supportive. However, they all indicated that at least one primary support person in their adult lives was essential in experiencing healing from CSA. This finding provides additional support for just how reparative a corrective emotional experience can be. Those that are abused in childhood do not necessarily sustain long-term damaging effects despite potentially living for years in isolation with their experience throughout their formative years of life. Participants in this study were not able to seek out support until they were on their own as an adult. As alone and isolated as children may feel, there can be light through the tunnel. This finding is important for those who work with trauma at any age group. It takes one healing relationship to be transformative.

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Appendix A: Recruitment Letter

Study on Positive Coping to Child Sexual Abuse
Principle Investigator: Kaylee L. Curilla, M.S.

We are interested in speaking with women who believe they have coped well over the years and have been able to make a positive adaptation to their experience of child sexual abuse. Individuals must also be willing to talk about the effects of the abuse on their current life. We are interested in speaking with people who have a history of repeated child sexual abuse by a loved one or other trusted individual.

To be in this study you must:
-age 50 or older
-Have a child sexual abuse history by loved one or other trusted individual
-Be willing to speak about experience of aging, emotional and mental health, coping, and how you made sense out of your experience

Time required for study participation will be about 1.5-2 hours. Participant will be given a written survey with questions about physical and sexual health. The investigator will interview the participant about how you made sense of the experiences of child sexual abuse, resiliency, coping, and emotional health will be discussed. This study will take place in participant's homes or a specific place that is easy for participants to get to.

A total of ten volunteers are needed. If interested, please contact Kaylee L. Curilla, M.S. at xxx-xxx-xxxx.

This study is part of a dissertation at Antioch University New England, under the supervision of Roger L. Peterson, PhD, ABPP.
rpeterson@antioch.edu
603-283-2178

Appendix B: Informed Consent

I am inviting you to participate in a study about healing from child sexual abuse. I am interested in how older women have found ways to cope positively with this experience throughout their lifespan. This study is conducted by Kaylee L. Curilla, M.S., as part of my doctoral dissertation. I am a graduate student in clinical psychology at Antioch University New England. My supervisor is Roger L. Peterson, PhD, ABPP.

You are being invited to participate in this study because you have indicated that you:

-are aged 50 or older
-have experienced repeated sexual abuse as a child, by a loved one or other trusted person
-have experienced the ability to recover since experiencing child sexual abuse
-are willing to write and speak about your experience of aging, emotional and mental health, and coping.

If you decide to take part in this study, you will *not* be asked to provide any details about your sexual abuse. You will be asked to:

Answer whether or not you agree or disagree with three statements about your attitudes towards sex.

Answer one question regarding whether you are satisfied or dissatisfied with your current sex life.

Be interviewed by me about your experience of aging, and what effect your sexual abuse experience has had on your emotional and physical health. You will also be asked general questions about your current and past sex life. The interview will last about 1.5 hours. Interviews will take place in a private location of your choosing.

Potential risks of participating in this study
It is possible that you will find it uncomfortable to talk about some of these experiences. You will be in control of the interview. You may choose not to answer any question any time you choose.

Potential benefits of the study
Other studies have shown that people experience relief from sharing difficult experiences. However, I cannot promise that you will get any benefit from this study. It is my hope that learning from women like you will help psychologists promote healing for other survivors of child sexual abuse.

We will protect your privacy.
I will audio-record our interview together. That digital recording and the written answers you provide for me will be kept in a secure location, without your name attached to them. I will use a numeric code to identify your data; I'll keep a list of numeric codes separately. Only the

researcher and the researcher's advisor will have access to the recording. The recording will be erased once the research is complete.

The information you share with me will become part of my report of this study. Some of what you say may be quoted directly in that report. I will not reveal any information that could identify you.

If you would like to see a transcript of the interview, you may contact the researcher at **xxx-xxx-xxxx.** You may remove any comments you do not wish to appear in the file.

Taking part in this study is your choice. If you do not take part, you will not lose any benefits or services. You may refuse to answer any questions that you find too stressful. If you are feeling uncomfortable or distressed, you may stop the interview at any time. In fact, you can change your mind about participating in the study for up to a month after you've been interviewed. All you need to do is call or e-mail me to tell me you'd like to withdraw from the study.

If you do experience negative reactions to what is discussed, and would like to speak to a therapist about them, you may contact Antioch Psychological Services Center to speak with a therapist at a reduced cost. Meeting with a therapist for one session may be beneficial in helping you to cope with distress. It may also be helpful to speak with someone for a longer time frame. Antioch Psychological Services Center is located at 40 Avon Street, Keene, NH 03431 and can be reached at 603-352-1024.

If you have any questions about the study, you may contact Kaylee.

If you have any questions about your rights as a research participant, you may contact Dr. Katherine Clarke, Chair of the Antioch University New England Institutional Review Board, 603-283-2162 or Dr. Melinda Treadwell, Vice President of Academic Affairs, 603-283-2150.

You will be given a copy of this form to keep.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THE INFORMATION PROVIDED ABOVE, ASKED ANY QUESTIONS OF THE RESEARCHER, AND DECIDED TO PARTICIPATE.

_____	_____
Date	**Name of Participant**
_____	_____
Date	**Signature of Participant**
_____	_____
Date	**Signature of Researcher**

Appendix C: Sexual Attitudes Questionnaire adapted from AARP Modern Maturity Sexuality Study of 1999

1. Sexual activity is critical part to a good relationship.

Strongly Agree	Agree	Somewhat Agree	Neither Disagree nor Agree	Disagree	Somewhat Disagree	Strongly Disagree
O	O	O	O	O	O	O

2. Sexual activity is important to my overall quality of life.

Strongly Agree	Agree	Somewhat Agree	Neither Disagree nor Agree	Disagree	Somewhat Disagree	Strongly Disagree
O	O	O	O	O	O	O

3. I do not particularly enjoy sex.

Strongly Agree	Agree	Somewhat Agree	Neither Disagree nor Agree	Disagree	Somewhat Disagree	Strongly Disagree
O	O	O	O	O	O	O

4. How satisfied are you with your sex life?

Extremely Satisfied	Satisfied	Somewhat Satisfied	Neither Satisfied nor Dissatisfied	Somewhat Dissatisfied	Dissatisfied	Extremely Dissatisfied
O	O	O	O	O	O	O

Appendix D: Interview Questions

1. How do you think getting older has affected your psychological health?
2. What has been the hardest part of getting older?
   a. What do you think is responsible for this difficulty?
   b. How does this compare with others that are in your age group?
3. Over the years, how has the sexual abuse affected your psychological health?
   a. Do you believe the sexual abuse has had any bearing on the choices you have made? If so, how?
   b. Has the abuse had any effect on your physical health?
4. Have you been able to make sense out of the abusive event?
5. Has the meaning you've attached to the abusive event changed for you over time?
6. How have you coped with the abuse?
   a. Did viewing the abuse in a certain way help?
   b. Who have you turned to for support?
      i. Was he or she supportive?
7. Were there events in your life that helped you do better with the experience of being sexually abused as a child?
   c. Graduation? Marriage? Birth of a child? Friendships? Relationships?
8. Have you noticed any recent changes in your ability to manage tasks of daily living or in any other areas of functioning?
9. Has getting older affected your physical health at all?
10. Do you feel bothered by any particular aspects of the getting older?
      i. Increased contact with medical field?

ii. Loss of autonomy?

iii. Loss of loved ones?