**(Re)Negotiating Realities: Gender- and Age-Related Factors Associated with Older
Trauma Survivors' Disclosure and Help-Seeking**

by

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Abstract

Despite the long-term aftereffects of childhood trauma, very few older trauma survivors disclose their traumatic experiences or seek help for their trauma-related problems. If they do disclose or seek help, they tend to talk to family or friends or seek help for only physical problems associated with their trauma. In light of this, the present qualitative study sought to understand what particular factors affected older trauma survivors' willingness to disclose their trauma or seek-help for their trauma-related problems. Semi-structured interviews were conducted with 8 women and 8 men ranging in age from 61 to 83 years old (M age = 70). These participants experienced a range of childhood traumas, including sexual abuse, physical abuse, neglect, warfare and internment in a concentration camp during World War II. The grounded theory analysis revealed that negative disclosure experiences (i.e., when the participants' trauma and its effects were not acknowledged or believed) served to exacerbate feelings of shame and fear that persisted throughout the participants' lives. That is, participants who felt that they could acknowledge their past (either because it was okay to talk about it or because their disclosure was believed) were less likely to need therapy and faring well psychologically in their later years. However, for participants who had their disclosures suppressed, rebuked or disbelieved, the feelings associated with those reactions became deeply ingrained in their understanding of their trauma as well as their "perceived" role in their traumatic experiences (i.e., feeling somehow responsible for the traumatic experience or as "damaged goods"). As a consequence, they continued to deal with the psychological and physical effects of their earlier trauma well into their later years. The discourse analysis revealed a number of gender- and age-related discourses in participants'

discussions during the interviews, discourses that had important implications for how participants understood their traumatic experiences and the likelihood that they would disclose these experiences to others. Implications for research and practice are discussed, particularly with regard to working with older trauma survivors and supporting their disclosure and help-seeking.

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I end with a note to my son, Leo, who bears the legacy of his grandfather's name with the hope that he, too, lives a life of generosity and compassion and the knowledge that people can make a difference, through the smallest gestures, through the kindness of words and through a commitment to understand.

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**(Re) Negotiating Realities: Gender- and Age-Related Factors Associated with
Older Trauma Survivors' Disclosure and Help-Seeking**

It scabs over, and then something will happen that will knock the scab off,
and it's all raw again.

- Daisy, 61-year-old survivor of child physical abuse.

Canadians are living longer than ever before and, as a result, the population of senior citizens in our society is growing rapidly. According to Statistics Canada (2011), 16% of women and 13.4% of men in Canada are 65 years of age or older, and these numbers are expected to almost double in the next 25 years. This aging population has a number of implications for society, one of which is the potentially overwhelming increase in the use of healthcare facilities and resources. What's more, this increased burden on the healthcare system may be exacerbated by older adults who are experiencing psychological or physical problems stemming from their earlier life experiences, experiences that all too frequently include some form of traumatization.

According to the American Psychological Association (1994), a traumatic event is one that "involves direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person" (p. 463). Many events have the potential to meet these criteria, some of which are more common in the lives of men (e.g., those associated with war) and others in the lives of women (e.g., child sexual abuse, adult sexual assault and partner abuse). Multiple studies have documented the frequency of traumatic life events in people's lives, including several studies of national samples. For example, using data from a

national comorbidity study in the United States, Kessler, Sonnega, Bromet, Hughes, and Nelson (1995) found that 60.7% of men ($n = 2,812$) and 51.2% of women ($n = 3,065$) aged 15 to 54 years reported experiencing at least one type of traumatic event during their lifetime. In particular, while women were more likely to experience trauma related to sexual abuse (21.5% of women vs. 3.5% of men), men were more likely to experience trauma related to combat (6.4% of men vs. 0% of women), three times more likely to be threatened with a weapon (19% of men vs. 6.8% of women) and over twice as likely to witness someone being killed (35.6% of men vs. 14.5% of women). Similarly, Norris (1992) interviewed 1,000 adults in the United States about their experience of trauma and found that, among the 321 participants who were sixty years of age or older, 69% had experienced at least one traumatic event, including the tragic death of a friend or relative (25.9%), robbery (24.1%), combat (20.4%), and a motor vehicle accident (19.8%). In addition, 11.7% had experienced a fire, 8.6% had been physically assaulted, 1.9% had been sexually assaulted, and 12.3% had experienced some other type of trauma.

These rates were mirrored in a recent study in New Zealand (Kazantzis et al., 2010). Of the 964 women and 536 men who took part in the study (M age = 45.4, $SD = 16.9$ years), 60% reported experiencing a traumatic event. Interestingly, women were more likely to experience a traumatic event in each of the categories examined by Kazantzis et al. (2010), categories that included crime (e.g., sexual and physical assault), hazards (e.g., natural disasters) and accidents (e.g., motor vehicle accidents or tragic death). Notably, the most common traumatic experience among women was sexual and physical assault. Moreover, 71% of women indicated experiencing sexual or physical assault, compared to only 29% of men.

Given these rates of trauma, the current research was designed to examine the dynamics associated with older adults' disclosure and help-seeking related to past trauma. In addition, the current research examined the gender- and age-related discourses older adult women and men use to describe their experiences of trauma,¹ their disclosure of their traumatic experiences to others and their help-seeking behaviour.

Impact of Trauma on Psychological Well-Being

Trauma survivors face a host of negative aftereffects, aftereffects that may last well into their senior years. For example, adult women who have survived child sexual abuse suffer higher rates of anxiety, eating disorders, self-destructive behaviour, low self-esteem, suicidal ideation, sexual problems and substance abuse than nontraumatized women (Briere & Runtz, 1987, 1988; Brown & Finkelhor, 1986; Lemieux & Byers, 2008; Ligezinska et al., 1996; Peleikis, Mykletun, & Dahl, 2004; Silverman et al., 1996; Thompson, Kaslow, Bradshaw-Lane, & Kingree, 2000). Men who have survived combat-related trauma and people who have survived war-related concentration camps are vulnerable to comparable psychological outcomes (Joffe, Brodaty, Luscombe, & Ehrlich, 2003; Kulka et al., 1990; Solomon, Dekel, & Mikulincer, 2008; Solomon & Prager, 1992). Although the psychological aftereffects of trauma are multifaceted and complex, two deserve particular attention: one, Posttraumatic Stress Disorder (PTSD), because it is a particularly deleterious outcome, and another, depression, because of its relevance to aging. The impact of trauma on physical health also merits consideration,

¹ The term *interpersonal* trauma refers to trauma that is *person-perpetrated* and *intentional*, as opposed to *non-interpersonal* trauma, which refers to events that are accidental and not person-perpetrated, such as car accidents and natural disasters.

particularly given the diverse nature of these effects and the challenges they pose to older adults.

Posttraumatic Stress Disorder (PTSD). PTSD is characterized by three sets of symptoms (American Psychiatric Association, 1994). The first set of symptoms involves persistent re-experiencing of the event in the form of nightmares, intrusive recollections, hallucinations, dissociative episodes, or intense psychological and physical arousal when exposed to situations similar to the traumatic event. A second set of symptoms involves persistent avoidance of stimuli associated with the trauma in the form of efforts to avoid thoughts, feelings, conversation, places or people reminiscent of the trauma. It also includes an inability to express a normal range of affect, decreased interest in activities, a sense of doom, and estrangement from others. The final set of symptoms characterizing PTSD involves persistent symptoms of increased arousal, including insomnia, irritability, anger, difficulty concentrating, hypervigilance and an exaggerated startle response. According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; APA, 1994), additional symptoms are associated with interpersonal traumas such as childhood sexual abuse, battering, surviving a concentration camp, being incarcerated as a prisoner of war, and being taken hostage. Sometimes referred to as Complex PTSD (e.g., Herman, 1992), these symptoms include difficulty modulating affect, self-destructive and impulsive behaviour, somatic complaints, feelings of ineffectiveness, shame, hopelessness and threat, hostility, social withdrawal, impaired relationships, and changes in personality.

Unfortunately, the passage of time does not necessarily bode well for trauma survivors as a sizeable number of older adults experience PTSD even years after

experiencing an interpersonal trauma, be it war-related trauma, such as the Holocaust, combat or being held as a prisoner of war (POW), or a form of violence against women and children, including child abuse, rape or partner abuse.

PTSD and aging survivors of war-related trauma and the Holocaust. A

substantial number of studies have documented PTSD in aging Holocaust survivors. For example, in their study of 124 Holocaust survivors, Kuch and Cox (1992) found a PTSD rate of 46.8% in 78 survivors who had been in concentration camps, of whom 20 had been tattooed and in Auschwitz (an extermination camp) and 45 had been in labour camps, ghettos or in hiding. Moreover, this rate increased to 51.3% among the concentration camp survivors in general and to 65% among the Auschwitz survivors in particular. Yehuda, Kahana, Southwick, and Giller (1994) reported similar findings in their study of 23 older adult Holocaust survivors. Despite the fact that these survivors were physically healthy and free of major psychiatric disorders (e.g., schizophrenia, dementia, and substance abuse), 48% had PTSD at the time of the study. More recent studies of older adult Holocaust survivors by Amir and Lev-Wiesel (2003), Brom, Durst, and Aghassy (2002), Joffe et al. (2003) and Yehuda et al. (2009) report similar rates of PTSD, as do studies of older adult combat veterans, where the observed rates of PTSD range from 14% to 67% (e.g., Jongedijk, Carlier, Schreuder, & Gersons, 1996; Sutker & Allain, 1996; Weintraub & Ruskin, 1999), and studies of now-senior POWs, where the observed PTSD rates range from 30 to 88% (e.g., Eberly & Engdahl, 1991; Engdahl, Dikel, Eberly, & Blank, 1997; Molinari & Williams, 1995; Speed, Engdahl, Schwartz, & Eberly, 1989; Sutker & Allain, 1996; Weintraub & Ruskin, 1999). More recently, Rintamaki, Weaver, Elbaum, Klama and Miskevics (2009) found that 16.6% of 157

American military veterans who were former WWII POWs met the clinical criteria for PTSD. Although these estimates of PTSD rates vary across studies, this variation is largely a result of differences in assessment procedures, the characteristics of the sample (e.g., clinical vs. nonclinical) and the intensity of trauma across studies. These studies indicate that, almost six decades after captivity, traumatic memories and clinically significant levels of PTSD still affect older adult holocaust survivors, war veterans and POWs.

Studies have also identified a number of factors that contribute to the likelihood of PTSD and/or the severity of PTSD symptoms following war-related trauma. Dikel, Engdahl, and Eberly (2005), for example, examined the extent to which various prewar factors (i.e., family closeness, family risk factors, and conduct disorder), war factors (i.e., combat intensity, prison camp trauma), and postwar factors (i.e., interpersonal connection and social interaction) accounted for the severity of the PTSD experienced by 160 now-senior POWs from the Korean conflict and WWII. Hierarchical regression analyses revealed that the severity of these POWs' PTSD varied as a function of prewar conduct disorder ($R^2 = .17$), intensity of combat, age at capture and the extent of their traumatization in the POW camp ($R^2 = .30$), and postwar interpersonal connection ($R^2 = .06$). Thus, while prewar and postwar factors contributed to these former POWs' PTSD, the severity of their trauma was the strongest predictor of the severity of their PTSD. Similar findings have been observed among aging Holocaust survivors (Kuch & Cox, 1992; Weisaeth & Eitinger, 1993). In addition, several studies have documented higher rates of PTSD among Vietnam veterans who had been physically or sexually abused during childhood, suggesting that trauma predisposes people to more extreme reactions to

subsequent trauma (Bremner, et al., 1993; for a review see Breslau, Chilcoat, Kessler, & Davis, 1999).

PTSD and aging survivors of violence against women and children. Although there is a large body of research examining PTSD on the part of older adult survivors of war-related trauma, no systematic study has examined the rates of PTSD in samples of now-senior survivors of violence against women and children. However, in Wickett and Kristiansen's (2008) study of 310 community-based people over the age of 60 who responded to calls for people to participate in a survey of "seniors' life experiences, coping and well-being," two women and two men (1.3% of the sample) met the clinical cut-offs for the three Trauma Symptom Inventory (Briere, 1995) scales that reflect PTSD (i.e., the scales measuring Intrusive Experiences, Defensive Avoidance and Anxious Arousal). Each of these older adults had experienced at least one type of violence against women and children. In particular, three had experienced child physical abuse and/or child sexual abuse, and three had experienced physical assault, rape and/or partner abuse. Similarly, the additional six women and six men (3.9%) who were classified as having partial PTSD² (i.e., they satisfied the clinical cut-offs for two of the three PTSD-related scales) had all experienced some form of violence against women and children. In contrast, of the 40 participants who had witnessed warfare or combat, the 16 who had war or combat experience, the one concentration camp survivor and the two prisoners of war, none was classified as having PTSD or partial PTSD.

²Studies suggest that the diagnostic criteria for PTSD may be too restrictive because they often exclude people suffering from clinically significant symptoms of PTSD. As a result, researchers often consider partial PTSD, which is sometimes defined as meeting the criteria for two of the three symptom clusters associated with PTSD (Schutzwohl & Maercker, 1999).

That older adult survivors of violence against women and children experience PTSD is also suggested by a number of case studies documenting the long-term effects of child sexual abuse (Allers, Benjack & Allers, 1992; McCartney & Severson, 1997; McInnis-Dittrich, 1996) and partner abuse (Osgood & Manetta, 2002; Wolkenstein & Sterman, 1998), as well as studies examining older adult women's experiences of symptoms related to PTSD. For example, Gentlewarrior (1997) found high levels of PTSD-related symptoms such as anxiety, dissociation and sleep disturbances in her postal survey of 125 professional women who had survived childhood sexual abuse. In addition, she found that the psychological distress of older women (i.e., 60 – 90 years old) did not differ significantly from that of younger women (i.e., 29 – 59 years old). Higgins and Follette (2002) also documented long lasting negative effects of violence toward women and children in a community sample of 102 women aged 60 years and over. In particular, women who experienced at least two types of interpersonal trauma (e.g., child physical/sexual abuse, adolescent sexual abuse and adult sexual assault) had higher levels of PTSD-related symptoms (e.g., anxiety, intrusive thoughts), global distress, and depression than older women who had experienced at most one type of interpersonal trauma. Given the high rates of PTSD found in younger populations exposed to child sexual abuse (30 – 90%; Kendall-Tackett et al., 1993; Paolucci, Genuis, & Violato, 2001; Rowan & Foy, 1993; Silverman et al., 1996), coupled with the similarity in the symptoms of younger and older women (Gentlewarrior, 1997), it is reasonable to assume that a substantial number of older adult survivors of violence against women and children suffer from PTSD.

Studies of younger populations indicate that a number of factors predict the likelihood of PTSD following child sexual abuse. In particular, PTSD is more likely following more intrusive abuse (i.e., involving penetration; Briggs & Joyce, 1997; Kendall-Tackett, Williams, & Finkelhor, 1993), abuse that began at an earlier age (Berliner & Elliot, 1996; Kendall-Tackett et al., 1993), abuse that continued for a longer duration (Berliner & Elliot, 1996), abuse perpetrated by someone close to the child (i.e., family vs. nonfamily member; Berliner & Elliot, 1996; Kendall-Tackett et al., 1993; Rowan & Foy, 1993), and abuse associated with the use of force or violence (Berliner & Elliot, 1996; Kendall-Tackett et al., 1993). Similarly, the onset of PTSD following sexual victimization and battering in adulthood is moderated by previous exposure to trauma, the use of physical force or weapons, the fear of death, and physical injuries (Breslau et al., 1999; for a review see Koss, Bailey, Yuan, Herrera, & Lichter, 2003).

Finkelhor and Browne (1985) proposed a process model to explain why trauma, specifically sexual abuse,³ has certain after-effects. Specifically, they argued that the experiences of betrayal, powerlessness, stigmatization and traumatic sexualization associated with child sexual abuse “alters a child’s cognitive or emotional orientation to the world, and create trauma by distorting children’s self-concepts, worldview, and affective capacities” (p. 532). Coping with these distortions, in turn, results in the psychological aftereffect of sexual abuse. For example, *betrayal* occurs when the survivor was betrayed by someone they trusted and who was vitally important in their

³ Finkelhor and Browne note that the traumagenic dynamics outlined in their model are not unique to sexual abuse and occur with other types of trauma. However, they argue that “the conjunction of these four dynamics in one set of circumstances is what makes the trauma of sexual abuse unique” (p. 530).

life, such as a parent or caregiver. This can lead to such outcomes as depression, an intense need to regain trust, and anger. *Powerlessness* refers to the powerlessness a victim of abuse feels due to their inability to stop the abuse. This, in turn, can lead to such things as fear, anxiety, and an impaired sense of self-efficacy and coping skills. *Stigmatization* refers to the negative connotations and isolation associated with being abused (e.g., being ashamed, feeling responsible). When stigmatization is incorporated into the victim's self-image, victims may feel guilt, shame, and low self-esteem. Finally, *traumatic sexualization* refers to the way sexual abuse distorts a child's sexual development and contributes to negative feelings regarding sexuality. This can lead to, among other things, negative attitudes toward their own sexuality and developmentally inappropriate sexual behaviour.

Finkelhor and Browne's delineation of the traumagenic dynamics is important because, although PTSD provides a descriptive account of the observed impacts of trauma, the traumagenic dynamics model identifies how trauma contributes to these symptoms. Interestingly, Kristiansen and Hay (2000; see also Reich, 1996) suggest that, among aging trauma survivors, aging is likely to replicate the traumagenic dynamics underlying trauma, including powerlessness (e.g., via increasing frailty or the staff-client power differential in senior care facilities), stigmatization (e.g., via ageism and sexism), betrayal (e.g., via neglect and abandonment by children) and retraumatization (e.g., via sexual and other abuse).

Although there is a paucity of research on the delayed-onset or re-emergence of PTSD in late life (for a review, see Hiskey, Luckie, Davies & Brewin, 2008), the studies that do exist indicate that PTSD may also appear in later life long after earlier symptoms

have remitted. It may also emerge for the first time in later life. Port (1998) observed this varied course and onset of PTSD in her four-year longitudinal study of 179 community dwelling World War II and Korean POWs. Overall, the rates of PTSD increased significantly across the four years of the study, rising from 27% at the outset to 34% four years later. Of the 34% of the now-senior POWs who reported PTSD, 29% reported symptoms shortly after the war and recovering fully by 1949, 17% reported symptoms for 30 years following the war and recovering fully by 1979, 18% reported continuous symptoms, and 11% reported intermittent symptoms over time. An additional 2% reported that their PTSD symptoms occurred for the first time after the age of 54 years. Thus 13% of these older POWs had either re-emergent or delayed-onset PTSD. In another study of 147 older adult Dutch resistance fighters (M age = 64 years; Op den Velde, et al., 1993), 55.8% displayed ongoing PTSD, 12% had PTSD that became more severe with age, and 56% had delayed-onset PTSD. Moreover, almost half (46.6%) did not manifest any symptoms of PTSD until at least 20 years after the war.

In sum, then, a good number of older adult trauma survivors, especially those exposed to more severe trauma, are vulnerable to PTSD.

Gender differences in the aftereffects of trauma. It is important to note that, although both women and men experience similar psychological difficulties following severe trauma and appear to manifest it in comparable ways (Elhai, Frueh, Gold, Gold, & Hamners, 2000), there is a sizeable literature indicating that adult women are more likely than adult men to suffer from PTSD following trauma (Breslau et al., 1999; Breslau, Davis, Andreski, & Peterson, 1991; Breslau, Peterson, Poisson, Schultz, & Lucia, 2004; Kessler et al., 1995). Breslau et al. (1991), for example, interviewed 1,007 people

between the ages 21 and 31 years (62% female) about their traumatic experiences and current psychological functioning. After controlling for the type of trauma and participants' previous exposure to trauma, the risk of PTSD was twice as high for women relative to men. This finding was subsequently replicated in Breslau et al.'s (1999, 2004) study of adults between the ages of 18 and 45. It is also consistent with the findings of an earlier study by Norris (1992).

Some researchers speculate that the gender difference in the likelihood of PTSD following trauma is due to women's increased risk of physical injury during trauma, the interpersonal nature of their traumatic experiences, and the presence of pre-existing disorders such as depression or anxiety (Breslau, et al., 2004; Kessler et al., 1995; Seedat & Stein, 2000). Because women who are sexually abused as children are at least twice as likely to be sexually assaulted or battered by their partners (Browne & Finkelhor, 1986; Green, 1993; Lang et al., 2004; van der Kolk, 1996; Vogel & Marshall, 2001), women may be more vulnerable to PTSD because they experience more interpersonal traumas than men. However, this explanation seems unlikely given that the gender difference observed by Breslau et al. (1991) occurred after the type of trauma and previous exposure to trauma were controlled statistically. Given this, other researchers suggest that the observed gender difference in PTSD may simply be an artifact of men's reluctance to report their symptoms in view of the social expectations conveyed by the stereotype that depicts men as strong and independent (Banyard, Williams, & Siegel, 2004). The possibility that women are truly more vulnerable to PTSD than men is nevertheless suggested by Sibai, Fletcher, and Armenia's (2001) finding that, among those who had

experienced war-related trauma, women were more at risk of cardiovascular disease than men.

In order to ascertain whether girls and women were more likely than boys and men to meet the diagnostic criteria for PTSD and whether this could be attributed to gender differences in the likelihood of experiencing trauma and the types of trauma, Tolin and Foa (2006) conducted a meta-analysis of 290 studies examining the prevalence of trauma and PTSD among females and males. Their results indicated that females were at a two-fold greater risk of being diagnosed with PTSD than their male counterparts. Interestingly, males reported more lifetime exposure to traumatic events, suggesting that the increased risk of PTSD among female participants is not due to an overall greater risk of trauma. In addition, females were more likely to experience child and adult sexual assault or abuse, whereas males were more likely to experience accidents, nonsexual assault, combat, disaster or fire, or serious illness. In order to assess whether the higher rates of PTSD among female participants could be attributed to higher rates of sexual abuse or assault, Tolin and Foa (2006) examined the frequency and severity of PTSD among female and male participants within the same category. They found that, overall, within the same trauma categories, females were not more likely to meet the criteria for PTSD than their male counterparts. These findings suggest, then, that the higher rates of PTSD among women compared to men cannot be accounted for by the type of trauma alone. However, gender differences in PTSD rates may be due to differences in the severity of the trauma experienced.

Regardless of the reason for the observed gender differences in the likelihood of PTSD following trauma, such findings point to the gendered nature of trauma. In

addition to differences in the extent to which women and men experience PTSD, trauma is also a gendered phenomenon because of the differential nature of the trauma that women and men experience. Whereas women are more likely to experience traumas such as sexual abuse, men are more likely to experience traumas such as combat or war. Acknowledging the gendered nature of trauma also involves recognizing that women's and men's life experiences, which are inherently gendered, can have a differential impact on their ability to cope with trauma (e.g., PTSD onset). Findings regarding the gender difference in the likelihood of PTSD also suggest that older adult women are more likely to experience and/or report trauma-related symptoms than older adult men. Moreover, the marked gender difference in the rates of PTSD, coupled with research indicating that social support, being married, good physical health and financial security are associated with fewer trauma-related symptoms (for a review see Weintraub & Ruskin, 1999), suggests that traumatized women face a double jeopardy as they age. Relative to men, women tend to live longer, are more likely to live alone, have poorer subjective perceptions of their physical well-being, and are more likely to live in poverty. These factors may serve to exacerbate any trauma-related symptoms. Indeed, poverty can not only lead to feelings of powerlessness and depression (Belle & Doucet, 2003), it can also be a significant barrier to psychological care. Older women, then, may be especially vulnerable to the cumulative effects of life-long gender-related and age-related inequalities (Milne & Williams, 2000).

Depression. Depression is a common psychological consequence of trauma (Lang, Stein, Kennedy, & Foy, 2004) and one that is also of interest to researchers studying aging. According to the DSM-IV (APA, 1994), depression involves a variety of

symptoms that cause significant impairment in social, physical and psychological functioning. These symptoms include depressed mood (e.g., feeling sad, empty), marked diminished interest or pleasure in most or all activities, significant weight loss, sleep problems, daily psychomotor agitation or retardation, fatigue, feelings of worthlessness or excessive, inappropriate guilt, memory impairment, and recurrent thoughts of suicide or suicide attempts. Associated features include somatic complaints (e.g., aches and pains), irritability, anxiety and obsessive rumination.

Depression is also one of the most common psychological problems experienced by the elderly (Milne & Williams, 2000). Like PTSD, the likelihood of experiencing depression is also two times greater among women than men (for reviews see Mazure, Keita & Blehar, 2002, and Sprock & Yoder, 1997). That this pattern persists into later life is indicated by Steffens et al.'s (2000) study of 4,559 non-demented people 65 years of age or older in the United States, where the lifetime prevalence of major depression was 20.4% among women and 9.6% among men (see also Kruijshaar et al., 2005; Takkinen et al., 2004).

The high rates of depression among traumatized older adults are well documented (e.g., Amir & Lev-Wiesel, 2003; Kraaij & De Wilde, 2001; Mullan & Oller, 1996; Unutzer, 2003). For example, in Kraaij and De Wilde's (2001) interviews with a randomly selected community sample of 194 elders between the ages of 65 and 94 (52% female), 77% reported experiencing at least one negative life event during their childhood (e.g., death, sexual/physical abuse, severe illness), 99.5% reported at least one negative life event during adulthood (aged 16 - 49 years), and 100% experienced a negative life event during late adulthood (aged 50 to current age). After controlling for age and

gender,⁴ lifetime experiences of sexual abuse (e.g., by parent, partner), relational stress (e.g., divorce from partner, broken relationship with child) and the death of significant others (e.g., father, child) accounted for 27% of the variance in respondents' depression scores. Lifetime experiences of physical abuse, emotional abuse/neglect, crime/disaster/war, the problem behaviour of significant others (e.g., suicide, addiction), severe illness (on the part of the self or others), and poor socioeconomic circumstances did not contribute to the equation predicting depression. In addition, and after controlling for age and gender, the number of negative life events experienced during adulthood (i.e., between the ages of 16 and 49), late adulthood (i.e., after the age of 49) and the childhood by adulthood interaction term explained 34% of the variance in depression scores. The latter interaction occurred because the relation between the number of negative life events experienced in adulthood was more strongly tied to current depressive symptoms for those who experienced more, rather than fewer, negative life events as a child. Thus, experiences of childhood trauma appear to make older adults vulnerable to the continuing negative effects of trauma experienced during middle-age.

Depression and aging survivors of war-related trauma and the Holocaust.

Although there is little systematic research examining the rates of depression in samples of aging survivors of war-related trauma (Conn, Clarke, & van Reekum, 2000), the research that does exist suggests that depression is common among them. In one study, Amir and Lev-Wiesel (2003) found that now-senior child survivors of the Holocaust ($n =$

⁴Given that both sexual abuse (e.g., Kessler et al., 1995) and depression (Mazure, Keita, & Blehar, 2002) are more common among women than men, controlling for participants' gender may have minimized the impact of earlier experiences of sexual abuse on seniors' depression.

43) were more likely to be depressed than their peers ($n = 44$) who had not experienced the Holocaust. Similarly, in a study of 23 Holocaust survivors, Yehuda et al. (1994) found that Holocaust survivors with PTSD had more depressive symptoms than those without PTSD and a demographically matched control group. Consistent with this, 15.3% of the Holocaust survivors in Kuch and Cox's (1992) study indicated that they were taking antidepressants.

Researchers have also documented high rates of depression among aging combat veterans. Southwick, Yehuda, and Giller (1991) found that 38% of 45 male psychiatric inpatients at a Veterans Administration medical center met the criteria for depression. Comparable rates of depression have been reported among aging POWs (Engdahl et al., 1997; Engdahl, Speed, Eberly, & Schwartz, 1991).

Depression and aging survivors of sexual abuse. Depression is also a common consequence of sexual and physical abuse (Beitchman et al., 1992; Bernet & Stein, 1999; Mullan & Orrell, 1996) and one of the factors that strongly differentiates abused from nonabused women (Koss et al., 2003). Research indicates that rates of depression range from 17 to 83% among women who experienced physical and/or sexual violence as a child or adult (Beitchman et al., 1992; Bernet & Stein, 1999; Campbell, Sullivan, & Davidson, 1995; Golding, 1999; Reid et al., 2009). Consistent with these findings regarding younger adult women, case studies also indicate that older adult women sexually abused as children (McInnis-Dittrich, 1996) and those battered by their partners (Wolkenstein & Serman, 1998) experience depression.

Although some research suggests that depression declines with age, Perkins-Newmann, Engel, and Jensen (1991) argue that the apparent decline in depression rates

may be due to age-related changes in the manifestation of depression. In their study of 251 community-based women (M age = 64 years), they found that elderly women were at an increased risk for a somewhat different depressive syndrome, one marked by feelings of depletion and social withdrawal rather than emotional distress and self-disparagement. In particular, symptoms of depressed mood and guilt became less prominent with age while somatic complaints such as weight loss, fatigue, social withdrawal and insomnia became more apparent (Dean-Crisp, 2004; Gintner, 1995; Perkins-Newmann, 1991). These findings are consistent with those of research indicating that older adults are more likely to experience the aftereffects of trauma as somatic, rather than psychological, complaints (Gintner 1995; Nichols & Czirr, 1986; Perkins-Newmann et al., 1991). To the extent that there are age-related changes in the manifestation of depression, then, the rates of depression among older trauma survivors may be even higher than those suggested by the research that has been conducted to date.

Not surprisingly, researchers have documented more severe depressive symptoms in people with PTSD relative to those without PTSD (Breslau, Davis, Peterson, & Schultz, 2000; Koss et al., 2003; Owens & Chard, 2003; Yehuda et al., 1994). For example, Owens and Chard (2003) found that current depression and avoidant personality disorder predicted the severity of the PTSD experienced by 89 adult women with a history of child sexual abuse, and suggested that this exacerbation of PTSD may stem from the overlap of the symptoms of PTSD with these two disorders (e.g., anxiety/agitation, relational problems). Similarly, Hofmann, Litz, and Weathers (2003) found that Vietnam veterans with PTSD reported high rates of major depression (59%) compared to veterans without PTSD, who reported no major depression. Thus, older

adults who present with depressive symptoms may also have PTSD stemming from historical experiences of trauma. Moreover, like PTSD, trauma-related depression may also re-emerge as trauma survivors age. In this regard, Barak et al. (2005) found that aging Holocaust survivors experienced a resurgence of trauma-related memories, despite having successfully suppressed them for years. This resurgence led to depression and, sometimes, attempted suicide. To put their findings into perspective, Barak et al. noted that, while 8.2% of patients attending an Israeli mental health facility attempted suicide, the attempted suicide rate among these aging Holocaust survivors was three times greater at 24%. Because women are more likely than men to experience depression, older traumatized women may be especially vulnerable to depression.

Trauma and physical health. Trauma also affects people's well-being. For example, survivors of childhood physical and sexual abuse generally report lower satisfaction with their overall health (Chartier, Walker & Naimark, 2007; Moeller, Bachman & Moeller, 1993) and are more likely to experience gastrointestinal problems, headaches, fatigue, pain, heart problems and disability due to physical health problems (Chartier et al., 2007; Goodwin, Hoven, Murison, & Hotopf, 2003; Leserman, 2005; Moeller et al., 1993; Sachs-Ericsson, Cromer, Hernandez, & Kendall-Tackett, 2009).

The presence of PTSD in older adults' lives is even more important to the extent that PTSD mediates the relation between earlier traumatization and poor physical health (Andreski, Chilcoat, & Breslau, 1998; Schnurr et al., 2000; Zoellner, Goodwin, & Foa, 2000). In a study of 1,007 adult members of a health maintenance organization, Andreski et al. (1998) found that those with PTSD were three to four times more likely to report somatic complaints relative to those without PTSD. In a study of 52 female Vietnam

veterans (M age = 48.7 years) who experienced both war-related and interpersonal trauma, Kimerling, Clum, and Wolfe (2000) found that both trauma exposure and PTSD symptoms predicted physical health symptoms such as forgetfulness, fatigue, restless sleep, backaches, and stomach cramps. Moreover, the effect of trauma on physical well-being was mediated by these veterans' PTSD symptoms.

Consistent with the findings of studies of younger adults, a growing body of research indicates that earlier traumatic experiences can have ongoing negative effects on older adults' physical health. Krause, Shaw, and Cairney (2004), for example, interviewed 1,508 people aged 65 and over (59% female) about their traumatic experiences and physical health status. They found that older adults who experienced more lifetime traumas (e.g., death of a spouse/child, partner abuse, and divorce) had poorer health outcomes as measured by self-rated health, number of health conditions (e.g., arthritis and hypertension), and level of difficulty with activities of daily living. Of particular interest is the finding that trauma encountered between the ages of 6 to 11 years, 18 to 30 years and 31 to 64 years had the greatest impact on current physical health. Specifically, for the young-old (i.e., 65 to 74 years of age), trauma that occurred between 18 and 64 years of age had an impact on all 3 health measures. For the same group, trauma experienced between the ages of 6 to 17 years had an impact on the number of health conditions only. Although no significant findings were found within the old-old group (i.e., 75 – 84 years old), data from the oldest old (i.e., 85 and older) indicated that trauma that occurred between the ages of 6 to 11 and 18 to 64 years had an impact on the number of current health conditions and functional disability. These findings are important because they indicate that trauma that occurs early in life can have

long-lasting impacts on the physical health of people in their old age. Similar findings were observed in a longitudinal study of 1,567 community-based people in Lebanon (*M* age = 61 years; 49.2% female), where those exposed to more war-related trauma had higher levels of cardiovascular disease and higher rates of mortality over the 10 years of the study (Sibai et al., 2001).⁵ In addition, of those who had experienced war-related trauma, women were more at risk of cardiovascular disease than men.

Studies of older adult Holocaust survivors, POWs and war veterans also report poorer health, more sleep problems, greater medication use and higher rates of morbidity among these groups relative to nontraumatized older adults (Joffe et al., 2003; Kuch & Cox, 1992; Landau & Litwin, 2000; Schnurr, Spiro, Aldwin, & Stukel, 1998; Stessman et al., 2008; Wagner, Wolfe, Rotnitsky, Proctor, & Erickson, 2000; Yaari, Eisenberg, Adler, & Birkhan, 1999). Similarly, fatigue, bleeding ulcers and more medication use has been documented among older adult women who experienced some form of violence against women and children (Allers et al., 1992; Higgins, 1999; McInnis-Dittrich, 1996).

Disclosure and Help-Seeking Behaviour

There are a number of factors that may contribute to the distress of aging trauma survivors, including the loss of family and work roles that served as meaningful distracters, the loss of friends and social support (Aarts & Op den Velde, 1996; Danieli, 1997; Krystal, 1981, 1995; Nichols & Czirr, 1986; Ornstein, 1981; Weintraub & Ruskin, 1999), declining physical health (Port et al., 2002; Weintraub & Ruskin, 1999), and institutionalization (Peters & Kaye, 2003). The impact of earlier trauma on older adults'

⁵This finding is particularly interesting in light of work by Krishnan (2002) indicating that medical illness, particularly cardiovascular disease, is a significant risk factor for major depression in late life.

psychological and physical well-being also appears to be mediated by the extent to which they engage in obsessive reminiscence and the frequency of their exposure to social stimuli that replicate dynamics similar to those they experienced earlier during their traumatization (Wickett & Kristiansen, 2008). Identifying the factors that contribute to older adult trauma survivors' distress is useful in that it suggests ways of intervening to enhance older adult trauma survivors' well-being. Given the above, for example, one might provide older adult trauma survivors with distracters and social support groups and expose them to interventions that reduce the extent to which they engage in obsessive reminiscence. These strategies, however, presuppose that practitioners and interventionists are aware of older adults' histories of trauma and, unfortunately, many trauma survivors do not disclose their trauma or seek help for their trauma-related difficulties. This reality was clearly conveyed by Dikel et al.'s (2005) discussion of the findings of their study of Korean conflict and WWII POWs and those of an earlier study by Engdahl et al. (1997):

One of the more poignant findings of this study was the degree of suffering experienced by these veterans so many years after the war. Many, if not most, contribute to society and lead productive lives. Most are invisible to the mental health system. At time 1, two-thirds of participants were receiving health care from a Veterans Administration (VA) medical center, but only 7% were involved in mental health care (Engdahl et al., 1997). It may be that lack of exposure to individuals who have managed to adapt to PTSD without our help contributes to the perception that only susceptible individuals are vulnerable to PTSD. As this is not the case, we are bound as researchers and clinicians, particularly given the apparent importance of posttraumatic interpersonal connection

in predicting PTSD, to find ways to reach out to the more adaptive survivors of trauma (p. 75).

Two aspects of this quote are relevant here. One is that 93% of these severely traumatized older adults did not seek mental health care, whereas two-thirds sought physical health care. Also relevant is the finding that posttraumatic interpersonal connection, which referred to the “perception of being listened to, understood, and able to talk to others about problems (emotional support)” (Dikel et al., 2005, p. 72), was associated with less severe PTSD. Given this, one has to ask what impeded these former POWs from talking about their trauma and seeking help. In a hierarchical regression analysis, Dikel et al. found that older adult POWs who had more negative childhood relationships with their parents ($R^2 = .14$), had prewar conduct disorder ($R^2 = .06$), and experienced more severe trauma in the POW camp ($R^2 = .02$) had lower interpersonal connection scores. Thus, the more severely traumatized POWs, who conceivably had the greatest need for emotional support, were least likely to believe they were listened to and understood by others and/or that they were able to talk about their problems.

Other researchers have also noted that now-senior POWs are unlikely to disclose their traumas or seek treatment for their trauma-related psychological difficulties (e.g., Buffum & Wolfe, 1995) and suggest that this group of trauma survivors is especially likely to minimize their symptoms and suppress their feelings (Molinari & Williams, 1995). Fortunately, and consistent with younger adults’ more positive attitudes toward those experiencing mental health problems (APA, 2005), younger members of the military appear to be more willing to disclose their traumas and seek treatment. In this regard, Bolton, Glenn, Orsillo, Roemer, and Litz (2003) found that 84% of 426 male peacekeepers deployed to Somalia (M age = 27 years) disclosed their traumatic

experiences which, despite their peacekeeping mission, included being on dangerous duty (61%), being fired upon (36%), and the hostile rejection of their help (32%). Of these Somali peacekeepers, 69% disclosed their experiences to a spouse, 69% disclosed to a family member, 62% to a close friend, and 78% to military colleagues. However, only 16% disclosed their traumatic experiences to a professional counsellor or member of the clergy. Interestingly, the peacekeepers who received supportive reactions to their disclosure to a spouse or family member had fewer PTSD symptoms than those who received negative reactions, and the PTSD scores of those who received negative reactions did not differ from those who did not disclose their traumatic experiences. Thus, it is not merely the act of disclosure, but the quality of support (i.e., the “perception of being listened to, [and] understood,” Dikel et al., 2005, p. 72) that appears to ameliorate the negative aftereffects of trauma.

Similar rates of help-seeking from professional sources were found among 315 military personnel (*M* age = 40 years) who served in the Persian Gulf War, the Lebanon War, or who were not deployed (Iversen et al., 2005). Of the 29% who reported various mental health problems (e.g., major depression, PTSD, anxiety disorders), 58.4% were currently seeking help. Of those who received treatment, 72% saw a primary care physician and 9% saw a psychiatrist. That so few of these middle-aged military members consulted a psychiatrist suggests that the stigmatization of mental health problems continues to be a significant barrier to peoples’ willingness to seek help.

Among older war veterans, the inability to disclose traumatic experiences is related to higher levels of PTSD. For example, Schnurr et al. (2000) found that PTSD levels of 716 male WWII veterans who had been involved in secret tests of the

effectiveness of equipment designed to minimize exposure to mustard gas varied as a function of their disclosure of their participation in the tests. During these experiments, the veterans were sworn to secrecy and, in some cases, told they would be criminally prosecuted if they disclosed. However, the tests eventually became public in 1990 and, as a result, the researchers were able to examine the impact of disclosures made up to 1990 and after 1990. As one would expect, the rate of full and partial PTSD was lower among the 213 veterans who disclosed their participation before and up to 1990 (39.4%) than it was among the 62 veterans who first disclosed their participation after 1990 (61.3%). Although the rate of full and partial PTSD was also low among the 38 veterans who never disclosed their participation to anyone (39.5%), the reliability of this estimate may be problematic given the relatively few men involved. In addition, “differential mortality may have resulted in the survival of the healthiest men, which may have attenuated some risk-factor relationships” (Schnurr et al., 2000, p. 265). Schnurr et al. (2000) also found that veterans with full or partial PTSD had poorer physical health than veterans without PTSD (e.g., heart problems, gastrointestinal disorders, sexual dysfunction). Thus, these findings suggest that delayed disclosure may be particularly detrimental to the psychological and physical well-being of aging war veterans.

A number of factors predict whether war veterans seek treatment for their trauma-related difficulties. These include their perceptions of their ability to deal with mental health problems on their own (i.e., perceived self-efficacy; Iversen et al., 2005; Solomon, 1989), the perceived stigma and embarrassment of consulting someone (Iversen et al., 2005), and the severity of their PTSD symptoms (i.e., those with more severe PTSD are less likely to seek help; Dikel et al., 2005; Hotopf et al., 2002; Solomon, 1989).

Like war veterans, many Holocaust survivors do not disclose their trauma or seek treatment for their trauma-related psychological symptoms (Danieli, 1997; Pennebaker, Barger, & Tiebout, 1989). For example, during interviews with 33 Holocaust survivors, Pennebaker et al. (1989) found that only 30% had ever talked to anyone about their Holocaust-related experiences. In addition, those who disclosed trauma reported fewer physical symptoms (e.g., headache, chest pain, shortness of breath) and were less likely to have visited a physician in the 14 months following their disclosure, suggesting that the more trauma survivors talk about their trauma, the better off they are. Common reasons for not talking about the trauma included trying to forget about the trauma (see also Danieli, 1997), not wanting to upset family or friends and, in line with the POWs in Dikel et al.'s (2005) study, feeling that no one would understand.

Victims of violence against women and children are equally unlikely to disclose their trauma or seek treatment. In telephone interviews with 3,220 women who had been raped before the age of 18 years, Smith et al. (2000) found that 28% had never disclosed their abuse before their participation in the study and, of those who had disclosed, half (52.2%) first disclosed more than five years after the sexual assault occurred. In addition, of the women who had disclosed, 22.5% disclosed to a close friend, 20.7% to their mother, 13.5% to other family members or relatives, and 7.4% to their husband. Only 6.6% of the women had disclosed the sexual assault to the police, a social worker or member of the clergy.

Similar findings were observed in Ullman and Filipas' (2005) study of 733 college students, where women (71%) were more likely than men (29%) to disclose their experiences of childhood sexual abuse, and both women and men were more likely to

disclose their sexual abuse to a friend (42.3% of women vs. 45.5% of men), a parent/relative (35.9% of women vs. 45.5% of men) or a sibling (10.3% of women vs. 18.2% of men) than to a formal healthcare provider such as a psychologist (2.7% of women vs. 0% of men). In addition, women who delayed their disclosure had more severe PTSD symptoms than women who disclosed sooner. The timing of men's disclosure, on the other hand, was independent of the severity of their PTSD symptoms, and men and women did not differ in the extent to which their disclosure was helpful. Overall, 44.9% said disclosing "made things better," 40.2% indicated it made "no difference," and 15% indicated that disclosure "made things worse." More recently, in a qualitative study of 40 adult CSA survivors (26 female, 14 male), Alaggia (2010) found that 42% had disclosed the abuse during childhood and 58% had either attempted some form of disclosure in indirect ways during childhood or not disclosed at all.

Other research has documented beneficial effects following the disclosure of childhood abuse (Bradley & Follingstad, 2000; Nagel, Putnam, Noll, & Trickett, 1997; Pennebaker & Susman, 1988; Ullman, 2007). In their review of studies of the effects of disclosure on well-being, Pennebaker and Susman (1988) found that people were less likely to disclose traumas experienced during childhood (e.g., sexual abuse, death of a family member) than adulthood (e.g., death of a family member, divorce). Moreover, relative to disclosed childhood traumas, those that were undisclosed were associated with poorer physical (e.g., high blood pressure, cancer, skin rashes) and psychological well-being (e.g., depression, anxiety).

As observed among the survivors of war-related trauma (e.g., Bolton et al., 2003), it is not simply the act of disclosure that ameliorates the aftereffects of childhood

sexual abuse, but the reactions of others to that disclosure (Ullman, 2003, 2007; Ullman & Filipas, 2005). Specifically, people who experience negative rather than positive reactions (e.g., disbelief) to their disclosures of child sexual abuse have poorer psychological outcomes and more somatic symptoms (Ullman, 2003). Moreover, Jonzon and Lindblad (2004) found that women who endured more severe childhood sexual abuse (i.e., longer duration, use of violence and multiple perpetrators) were more likely to experience negative reactions to their disclosure, such as anger, doubt and victim-blaming, than women who experienced less severe abuse. Indeed, Reavey and Warner (2001) contend that abused women who remain angry about their abuse risk being pathologized rather than supported. Thus, disclosure has the potential to detract from the well-being of the people in most need of assistance.

Survivors of sexual or physical assault during adulthood are also reluctant to seek treatment. It is generally acknowledged that most sexual assaults go unreported (Hattem, 2000). Indeed, victimization surveys from Statistics Canada (1993, 1999) indicate that only 10% of sexual assault cases are reported to police (Roberts, Grossman, & Johnson, 2003). Similarly, in a qualitative study of 22 women's experiences of the disclosure of partner abuse, Hanley (2004) found that more than half did not disclose their abuse to anyone until after they left the abusive relationship. In addition, Ullman and Filipas (2001) found that adult sexual assault victims ($N = 323$) received more negative reactions (e.g., stigmatizing responses, blaming the victim, telling the victim to "move on") when they sought assistance from formal health care providers, such as mental health professionals, physicians, and members of the clergy, than when they sought help from informal sources of support, such as friends and family.

That many survivors of violence against women and children do not disclose their traumas and that those who do are more likely to seek the assistance of informal (i.e., friends and family) than formal caregivers (i.e., psychologists, psychiatrists, physicians) was also apparent in the findings of a national U.S. study of 4,009 women (Lewis et al., 2005), where only 18.9% indicated that they sought help for personal or emotional problems. Of the women who sought help, 5.3% reported seeking help from a friend, 4.8% from a psychologist or psychiatrist, 3.3% from a counsellor, and 3.2% from a parent or other relative. Of interest here, women with a history of sexual or physical assault were more likely to report informal help-seeking than women without such histories, and women who met the criteria for PTSD and depression were more likely to seek help from both informal and formal networks. The latter finding is congruent with those of Ullman and Brecklin's (2003) study of 627 women who experienced childhood and adult sexual assault, where women with PTSD were 22 times more likely to seek help from health care professionals than those without PTSD. However, as is true of aging POWs (Dikel et al., 2005), the veterans involved in the tests of mustard gas (Schnurr et al., 2000) and perhaps the women in Lewis et al.'s (2005) study, Ullman and Brecklin note that this increase in formal treatment seeking by women with PTSD may have been for physical rather than psychological needs.

A number of factors predict whether adult survivors of violence against women and children disclose or seek treatment for their trauma-related difficulties. In particular, disclosure is more likely if it the assault was perpetrated by a stranger (Arata, 1998; Priebe & Svedin, 2008; Ullman & Filipas, 2001), lasted for a shorter duration (Nagel et al., 1997), and was less severe (Arata, 1998; Priebe & Svedin, 2008). Other factors that

affect disclosure include the perceived impact of disclosure on the family (especially if the abuse was perpetrated by a family member; Hanley, 2004; Hattem, 2000), fear of reprisal from the perpetrator (Hattem, 2000), fear of the criminal justice system (Hattem, 2000), and psychological functioning (Ullman & Filipas, 2005).

Older adult women are even less likely than younger women to disclose or seek treatment for their earlier experiences of violence against women and children. In Gentlewarrior's (1997) study of professional women with histories of childhood sexual abuse, only 14% of older women, as opposed to 27% of middle-aged women, reported receiving trauma-focused counselling. A number of factors probably contribute to older women's reluctance to disclose their trauma or seek treatment. One is the fact that older women, in general, are less likely to seek formal help than their younger counterparts. In this regard Lewis et al. (2005) found that only 4.2% of women aged 65 years or older, in contrast to 57.2% of women aged 18 to 64 years, reporting having sought formal help for their emotional and personal problems. Older adult survivors of violence against women and children may also be more unwilling than younger survivors to disclose their abuse because they grew up in a time when women were expected to be subservient to men and the subject of sex, let alone sexual abuse, was taboo (McInnis-Dittrich, 1996). Like their male counterparts (i.e., POWs; Dikel et al., 2005), older adult women may also be reluctant to disclose or seek help for their trauma-related difficulties because they fear not being taken seriously or listened to. Unfortunately, these fears may be realistic. Adult children, for example, often refuse to believe their mothers' disclosures of partner abuse (McLeod, 1994). Similarly, in a qualitative study of older women's experiences of

healthcare, Kinch and Jakubec (2004) found that older adult women were concerned about two things, namely “not being taken seriously” and “not being listened to.”

Gender- and Age-Related Discourses Regarding Trauma

How people construct and describe their experiences, including their traumatic experiences, is intimately intertwined with their social, historical and cultural context. As sociopolitical contexts change, new explanations for various phenomena become part of people’s everyday language, reflecting the available discourses circulating within that culture. According to Burr (1995), a discourse refers to “a set of meanings, metaphors, representations, images, stories, statements, and so on that in some way together produce a particular version of events” (p. 48). This can take the form of an “interpretive repertoire,” a discursive resource speakers use to construct their particular understanding or version of events (Wood & Kroger, 2000). The term *discursive psychology* was adopted to emphasize that “discourse analysis is not just another mode of empirical analysis but provides an alternative theoretical perspective on social life” (Wood & Kroger, 1993, p. 264). According to discursive psychology, and consistent with social constructionism, the primary human reality is talk.

Social constructionism refers to the various ways social reality and social phenomena are constructed. Burr (1995) outlines a number of assumptions underlying social constructionist thought. First, knowledge is viewed as subjective. In other words, social constructionists are critical of the idea that conventional knowledge is objective and unbiased. Thus, social construction involves subjective, rather than objective, reality. Second, historical and cultural specificity are deemed to affect our understanding of the world. At any given time, social definitions may vary as a function of the particular

historical or political context. A third assumption is that knowledge is sustained by social processes. In this regard, it is through our social interactions with others that versions of “reality” and “subjective knowledge” are created. The final assumption underlying social constructionism is that knowledge and social action go together.

A critical component of social constructionism, and one that differentiates this philosophy of science from traditional positivist or post-positivist psychology, is the importance given to language. Social constructionists regard language as the key vehicle by which people think and make meaning (Burr, 1995) and the medium by which people construct their world and their sense of “self” (Potter & Wetherell, 1987). In other words, our identity is constructed out of a multitude of culturally available discourses and is connected to the way society is both organized and managed (Wood & Kroger, 2000). Indeed, self-experience is formed as people learn the language and “conversationally acceptable ways of presenting oneself as a person” (Potter & Wetherell, 1987, p. 107).

Not surprisingly, the discourses that are available to people, that is, their interpretive repertoires, have implications for how people construe their experiences and what they can and cannot, or will and will not, do. Relevant here are the potential effects of gender- and age-related discourses on older adult trauma survivors’ understandings of their trauma and its aftereffects and their willingness to disclose or seek help for their trauma-related difficulties.

Gender-related discourses relevant to trauma. Researchers have documented gender-related discourses regarding a number of traumas, including childhood sexual abuse, the sexual assault of adults, partner abuse and combat. For example, Krause, DeRosa and Roth (2002) contend that gender socialization affects both the way people

make sense of their experiences of childhood sexual abuse and how they adapt to its aftermath. As evidence, Krause et al. describe how female and male sexual abuse survivors differ in their experiences of, and reactions to, four themes common to trauma survivors, namely *self-blame/guilt*, *helplessness/powerlessness*, *legitimacy*, and *anger/fear*.

As Krause et al. explain, trauma survivors often experience *self-blame or guilt* because they hold themselves responsible for the trauma they encountered. Women who have been sexually abused tend to hold themselves responsible by viewing themselves as having instigated or provoked the abuse (e.g., by regarding themselves as “a slut”). Thus, women’s experience of self-blame or guilt is consistent with a social discourse that holds women responsible for men’s sexual behaviour. Men who have been sexually abused are also likely to hold themselves responsible for their abuse, but do so by blaming themselves for not being “man enough” or “smart enough” to stop the abuse. Hence men’s experience of self-blame or guilt is consistent with social discourse that depicts men as strong and self-reliant. Further, that the characterological self-blame displayed by some women is associated with poorer coping outcomes, while the behavioural self-blame displayed by some men facilitates a sense of control over future vulnerability and thereby coping (Janoff-Bulman, 1992), may explain why women are more vulnerable to PTSD than men.

According to Krause et al., sexual abuse survivors’ narratives also suggest that the feelings of *helplessness* and *powerlessness* that follow sexual assault stem from cultural constructions that associate femininity with characteristics such as passivity and dependence. Sexual assault, therefore, reinforces these constructions. However, because

feelings of helplessness and powerlessness are discrepant with social conceptions and discourses regarding masculinity, men and women are likely to use different ways to regain their sense of control. In particular, while women may try to reinstate their feelings of power and control through bodily self-harm or sexual exploitation (e.g., risky sexual behaviour, prostitution), men may try to increase their feelings of power by physically dominating other people or engaging in aggressive behaviour. This is consistent with research indicating that women tend to internalize their problems following abuse (e.g., via depression, social withdrawal; Briere & Elliott, 2003; Finkelhor, 1990; Gibson & Leitenberg, 2001; Ullman & Filipas, 2005), whereas men tend to externalize their abuse-related problems (e.g., via anger, aggression; Finkelhor, 1990; Romano & De Luca, 2001).

In addition, Krause et al. contend that the differential effects of gender socialization are also evident in sexual abuse survivors' descriptions of *legitimacy*, which refers to the degree to which they believe that their current emotional experiences are due to their previous traumatic experiences. Survivors of sexual abuse often describe their reactions to the abuse as deviant or invalid. According to Krause et al., some survivors think they are "crazy" because they overreact to situations that seem unrelated to abuse and others actually doubt that the abuse occurred. As a result, survivors' attempts to legitimize their experiences of abuse may be thwarted and they may turn to social cues to inform them of more appropriate ways of understanding their experience (e.g., women viewing "date rape" as consensual intercourse, Wood & Rennie, 1994). Ultimately, this process is self-silencing. On the other hand, a major obstacle to men's sense of legitimacy stems from society's failure to view men as victims. As a result, many male

survivors may downplay the aftereffects of their trauma. In light of this, it is not surprising that male war veterans and POWs minimize their trauma-related symptoms (Molinari & Williams, 1995) and frequently do not seek help for their trauma-related difficulties. In a qualitative study of 16 men (aged 24 to 61 years) who had been sexually abused as children, Sorsoli, Kia-Keating, and Grossman (2008) found that most of the men did not disclose their abuse experiences because “it was unacceptable for men to experience victimization and if they had, that they were certainly not to discuss those experiences” (p. 341). Thus, a powerful societal discourse that depicts men as non-victims impedes male trauma survivors from talking about their trauma-related experiences and/or problems.

Finally, the fourth theme considered by Krause et al. concerns *anger* toward the event and the perpetrator and *fear* of repeated abuse, emotions that are commonly experienced following childhood sexual abuse. Although women and men give the same descriptions of their fear, they differ in their experience of anger. For women, feelings of anger and rage at the perpetrator may be frightening because they are discrepant with the social construction of femininity as involving passivity, powerlessness and niceness. As a result, women may suppress these emotions and this, in turn, may exacerbate their feelings of helplessness and powerlessness. In contrast, anger is probably the only trauma-related emotion that does not contradict the social construction of masculinity. As a result, male trauma survivors may rely on anger as their sole emotional outlet, while denying their feelings of vulnerability and depression. Alternatively, the view of men as unemotional and inexpressive (Kiesling, 2005) may inhibit male trauma survivors from outwardly displaying any emotional turmoil. Hence, discourses of masculinity that

depict men as strong, authoritative and in control (Kiesling, 2005) may compel older male trauma survivors to essentially suffer in silence.

In addition, discourses that associate the sexual assault of men with homosexuality may impede men's disclosure of sexual assault (Hartill, 2009; Norton, 1997; Sorsoli, et al., 2008). Similarly, discourses regarding 'machismo' have been observed to inhibit male war veterans from disclosing their trauma-related symptoms. In a historical review of PTSD among World War II veterans, Buffum and Wolfe (1995) examined how most male war veterans refused to seek treatment for any psychological symptoms because they "were not aware of emotional responses to combat" (p. 265). Buffum and Wolfe (1995) contend that one explanation for this is that male war veterans were inhibited from disclosing their trauma-related symptoms or seeking help because they feared being seen as weak or having their symptoms attributed to cowardice.

Common social views of victims, sexual abuse and responsibility also play a role in how women formulate their experiences of rape. In a qualitative study, Wood and Rennie (1994) interviewed eight women (aged 18 to 30 years) who had been raped by a date, an acquaintance or a family member. During the interview, these women used various discursive strategies, such as excuses and justifications, to negotiate non-victim identities for themselves. In particular, the women had difficulty naming what happened to them as rape (e.g., "I'm calling this date rape, as you said it's rape. I see rape as more violent, but maybe ...") and used language that implied control and consent (e.g., "I shouldn't have gone into that house that night ... I should have known the guy was drunk."). Thus, common social views of victims, sexual abuse and responsibility played a significant role in how these women understood their experiences. In addition, by not

calling it “rape” the women avoided confronting the situation, avoided being labelled a victim, and avoided being viewed differently by society.

Coates and Wade (2004) found similar linguistic strategies in the legal trial judgments of cases involving perpetrators who had sexually abused or assaulted women. In 55 of the 64 judgements they analyzed, the judges’ reformulated the violent sexual assaults as nonviolent, consensual events. For example, rape was reformulated as “intercourse,” violating physical contact as “fondling,” and a man sticking his tongue in a woman’s mouth against her will as “French kissing.” These reformulations served to put part of the responsibility on the victim, rather than solely on the perpetrator. Coates and Wade also identified four “discursive operations” that had the effect of blaming the victim. These included linguistic devices that concealed the abuse (e.g., characterizing rape as “intercourse”), mitigated the perpetrators’ responsibility (e.g., “he was influenced by alcohol”), concealed the victims’ resistance (e.g., portraying the victims as passive objects who incited sexual desire in the perpetrator), and blamed or pathologized the victims (e.g., positioning victims as “troubled” or “unreasonable”). As noted by Coates and Wade, such characterizations have serious implications for how sexual abuse victims are treated because they call for radically different actions (i.e., prosecution or no prosecution). Such characterizations are also likely to have equally profound implications for the likelihood that women will disclose their assault or seek treatment for its aftereffects.

More recently, Crocker (2005) found some of the same discourses in judges’ decisions in cases of intimate violence against women. For example, judges mitigated perpetrators’ responsibility for battering their partner by making statements about his

character (e.g., his behaviour was “out of character”) or his previous record (e.g., “the accused has no previous record”). Victim-blaming was evident in judges’ statements about the woman’s lack of credibility (e.g., being argumentative in court, angry, not “acting properly” or being a bad mother) and her (mis)conduct (e.g., claims that her conduct drove the man to assault her, questioning why she had not left the abusive relationship). In addition, much of the condemnation of violence came from the notion that battered women are weak, vulnerable and in need of protection. As a result, judges tended to emphasize protection and too often minimized the violence or blamed the woman.

Finally, Hanley’s (2004) analysis of her interviews with 22 battered women revealed four main discourses in women’s discussions of their decisions to disclose their abuse by their partner, discourses that had different implications for their disclosure. In the “battered woman” discourse, being battered is equated with severe acts of ongoing violence that produce visible damage such as bruises and broken bones. This discourse detracted from women’s understanding of psychological abuse as abuse and the negative impact of such abuse on women’s psychological well-being, constricted their perception that they were actually battered and, not surprisingly, made them less likely to disclose the abuse. The “victim identity” discourse, which depicts women as helpless and weak, made women unwilling to disclose their abuse because they were reluctant to be viewed as weak and helpless. Discourses of “femininity,” which involve cultural constructions of the “good woman” as one who is nurturing, self-sacrificing and responsible for the care and well-being of others (Stoppard, 2000), also detracted from women disclosing their abuse because it made them feel responsible for the abuse and failing to attain this

cultural ideal in their relationship. Finally, in relating their experiences of disclosing their abuse, the women described acquiring a positive discourse that helped them overcome the negative effects associated with the abuse. This discourse of “empowerment” (e.g., “Why do I think he’s so much superior to me?,” “It’s made me more independent”) helped women question assumptions about power, resist the idealized version of the “good woman,” and become aware of their own strengths.

In view of the above, it seems likely that older women and men will construe their own experiences of both their trauma and its aftereffects through the lenses of the gender-related social discourses available to them. Moreover, the extent to which they do so may well detract from their disclosure of their traumas and their treatment seeking.

Age-related discourses relevant to trauma. There are a number of prevailing discourses around aging and the aged that perpetuate negative attitudes and stereotypes about older adults and threaten older adults’ self-esteem and quality of life (Coupland & Coupland, 1993). In turn, these discourses may detract from older trauma survivors’ understanding of their traumas and its aftereffects, as well as the likelihood that they will disclose their trauma and seek treatment. In particular, discourses that construct older adults as “frail,” “childlike,” and “dependent on society for care” depict older adults as powerless and thereby uphold the power inequality that currently exists between the young and the old and between caregivers and caretakers (Ng & McCreanor, 1999; Stephenson, Wolfe, Coughlan, & Koehn, 1999; Wood & Kroger, 1993). These discourses also suggest that older adults will not be “taken seriously,” “listened to” or “understood” and, as a result, may detract from older adults’ willingness to disclose their trauma or seek treatment (e.g., Dikel et al., 2005; Kinch & Jakubec, 2004).

According to Wood and Kroger (1993), the ability of certain discursive practices to constrain older people is illustrated by the forms of address used with older adults, forms of address that serve special pragmatic functions in that they encode social relationships and communicate positions of power. Specifically, after analyzing conversations between physicians and elderly patients, Wood and Kroger concluded that certain forms of address put elderly people in positions of powerlessness. These include addressing an elderly patient by their first name, which may indicate that the status of the elderly person has declined, or saying their first name loudly and often, which may reflect the belief that the older person has certain cognitive impairments that make the repetitive use of their first name warranted even though they do not have any disability. Other forms of address also render older adults powerless, including those that infantilize older adults (e.g., calling older women “sweetheart” or “girl”) and “provide specific linguistic devices for rendering older adults into children” (Wood & Kroger, 1993, p. 273).

This “disempowerment” of older adults is consistent with the findings of Nussbaum’s (1993) observational study of communication in a nursing home. Observing the admission of an 82-year-old woman into a nursing home, he noted an over-emphasis on dependence that reinforced the existing stereotype of nursing homes as places where older adults lose their independence and ultimately go to die. For example, the older adult woman was not an active participant in the admission process in that very little talk was directed toward her and, when it was, it involved explaining non-negotiable procedures (e.g., when her family could visit, when she would be awakened and put to sleep, when others could phone). Nussbaum argued that this type of communication (or lack of) reinforced the resident’s dependence (or imminent loss of independence).

Grainger (1993) observed similar discursive practices during nurses' interactions with 30 elderly patients in two long-term care facilities. During their interactions, she found that the patients were objectified and that the requirements of the institutions were prioritized over the needs of the patients (e.g., responding to an elderly man's comment that he was not feeling well by instructing him to get up and begin the daily routine, rather than responding on a personal level to his problem). Specifically, Grainger identified four modes of discourse. *Routine management discourse* (e.g., "take your dress off," "stand up a minute") was part of the nurses' task-orientated goals but put the nurse in a controlling position and, by implication, defined the patient as passive. *Nurturing discourse*, which was comprised of a loving, intimate style of discourse (e.g., "alright my darling"), cast the nurse in a nurturing role and the patient in a needy, dependent role. *Sick/dependent discourse*, which involved patients' complaints and expressions of pain and discomfort (e.g., "it's too painful"), reinforced the resident's dependence when the nurse expressed sympathy. Finally, *personal discourse* involving sociable, non-institutional talk between nurses and patients (e.g., "where's your home?") was rarely engaged in, or responded to, by nurses. Grainger suggests that these types of exchanges contribute to older residents' loss of identity and self-esteem, their loss of control over themselves and their environment, and their lack of meaningful social contact.

In addition to the routine discursive disempowerment of older adults, a number of other discourses have the potential to detract from their willingness to disclose their trauma or seek help for any trauma-related problems. The saying, "You can't teach an old dog new tricks," for example, may lead older adults to believe that they cannot benefit from therapy. Similarly, older adults may believe that pursuing therapy is not

worthwhile or justified because they “don’t have long to live.” Age-related stereotypes may also inhibit older adults’ willingness to admit that they are experiencing certain trauma-related symptoms, and therefore impede them from seeking help. For example, aftereffects associated with anxiety, particularly trembling and shaking, and depression would be consistent with negative stereotypes that depict older adults as frail and helpless. Alternatively, like some clinicians (Nichols & Czirr, 1986), older adults may misattribute such symptoms to the normal process of aging.

Taken together, then, prevailing discourses around gender and age illustrate that everyday conversation or discourse may reproduce social injustices and inhibit effective intervention (Coates & Wade, 2004) for older trauma survivors because they impede older adults’ understanding of their trauma and their trauma-related symptoms and, thereby, their disclosure and help-seeking behaviour.

Current Research

Although there is a growing body of research on the long-term effects of trauma, to date there are no qualitative studies of how older women and men construe their trauma and their trauma-related symptoms. Rather, as noted by Hyler (1999, pp. 553-554), researchers,

have ignored many “critical” questions. Research on the organization, decision rules and best exemplars of PTSD at later life have been left behind. What really is PTSD at later life? If an older victim has a few intrusion and arousal symptoms, but no evident avoidance problems, what does that mean? ... how are narratives defined – in terms of textual structures, social interactions, or cultural issues? ... And with regret, we simply assume that the *DSM* is the best model for the categorization of a person who experiences trauma.

The study of the response to trauma is really an illusion, a coterie of variables that hang together in psychological space. Trauma symptoms represent only memory markers that capture moments of traumatic schemes of helplessness, terror, horror, and utter ineffectiveness. The *DSMs* create order, but imperfect ones and ones that do not provide clear treatment rules. The value or meaning of a symptom in the context of PTSD for an older person requires something simple, a clinical ear.

There is also limited research on older trauma survivors' disclosure and help-seeking⁶ experiences. Alaggia (2010) proposed an ecological theoretical framework that is useful to understand disclosure within the context of trauma, namely childhood sexual abuse. Specifically, Alaggia argues that individual behaviour related to disclosure can only be understood within the context of ontogenic, micro-system, exo-system and macro-system levels. *Ontogenic level factors* refer to the personal history and characteristics of the individual. *Micro-system level factors* are factors related to the family environment and family characteristics. *Exo-system level factors* refer to neighbourhood and community influences. Finally, *macro-system level factors* refer to cultural and societal attitudes regarding disclosure and abuse more generally.

The over-reliance on traditional methods in existing research with aging trauma survivors (e.g., quantitative surveys) suggests that new methods may help elucidate the meaning of trauma and trauma-related symptoms for older adults. In light of this, the current research examined the *ontogenic*, *micro-system*, *exo-system* and *macro-system*

⁶ For the current study, *disclosure* refers to the act of telling someone about a traumatic experience, whereas *help-seeking* refers to talking to a professional such as a psychologist or psychiatrist about trauma-related problems (e.g., depression, anxiety).

level factors that influence disclosure and help-seeking among aging trauma survivors using qualitative research methods, namely grounded theory analysis and discourse analysis. Specifically, the current research examined the personal factors affecting why aging trauma survivors decided to disclose or seek-help across the lifespan. This research also sought to shed light on how current discourses of gender and aging relate to older adults' understandings of their own trauma and trauma-related symptoms, as well as their disclosure and treatment-seeking behaviour.

Method

Philosophical Paradigm and Research Design

Qualitative methods were deemed appropriate for this research because the goal of this study was to investigate older adults' subjective experiences of the aftereffects of trauma and the factors that they believed contribute to whether they disclosed their trauma or sought help for their trauma-related experiences. It was also the aim of this study to understand how current discourses around trauma, gender and age relate to older adults' understandings of their trauma, the extent to which they talk to others about their trauma, their help-seeking behaviour and their well-being. As stated by Wood and Kroger (2002), "the use of numbers to designate categories or quantities is at best premature if those categories are unclear" (p. 137).

Throughout this research, the guiding theoretical framework was social constructionism. Specifically, the research process was viewed as subjective and observations were seen as products "of the social processes and interactions in which people are constantly engaged with each other" (Burr, 1995, p. 4). In addition, in order to understand the potentially gendered dimensions of trauma and aging, I assumed a feminist standpoint, particularly in regard to issues of power and control.⁷ I consider myself to be a *multiracial feminist*, an overarching concept that embraces several strands of feminist theory. Multiracial feminism asserts that gender is constructed by a range of interlocking inequalities (e.g., race, gender, age, class, sexuality). Indeed, "women and

⁷ Throughout the research process, I kept a personal reflexivity journal which helped me to question some of the assumptions and biases I had regarding women and men who had survived trauma. It also helped me to understand how my own personal beliefs influenced the research, including my particular perspectives on gender equality.

men are differently embedded in locations created by these cross-cutting hierarchies. As a result, women and men throughout the social order experience different forms of privilege and subordination, depending on their race, class, gender, and sexuality” (Zinn & Dill, 1996, p. 327). Hence, the research was considered from the perspective of women’s lives, which led to questions regarding how older women are oppressed and how women’s unique experiences of inequality affect their lives. Moreover, the research was also conducted considering the perspective of men’s lives, and led to questions regarding how male trauma survivors, influenced by social discourses that assert their power, deal with being vulnerable or in positions that are typically seen as “feminine.”

Recruitment

The participants were sampled in two ways. Seven participants were purposively sampled from among 310 women and men over the age of 60 who took part in an earlier study where they indicated their level of disclosure and their level of help-seeking regarding previous traumatic experiences and who were experiencing moderate to clinical levels of the symptoms that define posttraumatic stress disorder (Wickett & Kristiansen, 2008). In Wickett and Kristiansen’s (2008) survey, participants answered questions derived from Higgins and Follette’s (2002) study of older adult female trauma survivors, the Life Stressor Checklist Revised (Wolfe & Kimerling, 1997), the Life Stressor Checklist (Norris, 1992) and Traumatic Life Events Questionnaire (Kubany et al., 2000) assessing their exposure to various interpersonal (e.g., physical assault, childhood sexual and physical abuse) and noninterpersonal traumas (e.g., earthquake, car accident). In addition, PTSD was measured by the Trauma Symptom Inventory-Alternate (TSI-A;

Briere, 1995),⁸ where respondents used 4-point scales ranging from *Never* to *Often* to rate the frequency of 84 experiences in the previous 6 months. Participants who indicated that they had experienced sexual or physical abuse as a child, adult and/or older adult, combat or military service, imprisonment in a concentration camp, or being a POW, and who indicated their willingness to participate in a subsequent interview were eligible to participate in the current study.

Purposive, criterion-based convenience sampling was used to recruit the remaining nine participants. These participants responded to posters and newspaper advertisements calling for women and men aged 60 years and older who had experienced a trauma as a child to participate in a 1.5 hour interview about their experiences. To the extent possible, efforts were made to vary participants by gender, type of trauma and the degree to which they did or did not disclose their traumatic past or seek help for problems associated with their traumatic experiences.

Interviews

Once participants indicated interest in participating in an interview, they were contacted via telephone and invited to participate in a semi-structured interview that, with the participant's consent, was tape-recorded. All of the interviews took place in the home of the participants. The length of the interviews ranged from 1.5 hours to 4.5 hours (M length = 2.5 hours).⁹ At this time, they were told about the purpose of the study (i.e., the

⁸Although the TSI-A does not provide a direct measure of PTSD, it is possible to assess PTSD indirectly by examining respondents' scores on particular scales, namely the intrusive experience, defensive avoidance and intrusive experience scales.

⁹ All of the participants were very forthcoming in their responses and indicated a willingness to talk about their trauma despite the fact that, in some cases, they had not talked about their trauma in over 60 years or had never disclosed their traumatic experiences to anyone.

impact of trauma on older adults' well-being and their disclosure of their trauma and help-seeking behaviour) and the content of the interview questions (i.e., specific questions about their trauma, current well-being, disclosure and help-seeking). A mutually convenient time and place for the interview (e.g., in their home or the university) was arranged with those who agreed to participate.

Before conducting the interview, participants read and signed a consent form and were assured that they could withdraw themselves and their data from the study if they desired. In addition, they were assured that their confidentiality and anonymity would be maintained. I also discussed the possibility of negative feelings arising due to the subject matter and explained that, although I was not qualified to offer counselling, I could provide them with a list of support resources available in the Ottawa-Carleton area and free consultation with a registered clinical psychologist.

To establish rapport with participants and give them a sense of their ability to participate (Berg, 2004; Fontana & Frey, 2000), the semi-structured interviews started with a question asking them why they decided to take part in this study (see Appendix A for the Interview Protocol). This was followed with easy-to-answer background questions. General guiding questions were then used to ask about participants' previous traumatic experiences (including information about the severity of the trauma such as its duration and frequency and their age at the time it occurred) and the impact of the trauma on them both in the past and now. When necessary, questions were asked about their experience of symptoms consistent with discourses of femininity (e.g., helplessness, loss of control) and masculinity (e.g., anger). Participants were then asked about their disclosure of their traumatic experience(s), both in the past and more recently. These

questions asked how often, to whom and when they disclosed, as well as for information about the reactions of the recipient(s) of their disclosure(s). Participants were also asked whether they had ever felt the need to talk about their trauma but did not and, if so, to describe an instance of this experience, including the contextual circumstances and their thoughts and feelings at the time. Those who reported never disclosing their traumas were asked to explain what they thought might happen if they did tell someone about their experience. Questions comparable to these disclosure questions were asked regarding participants' treatment seeking behaviour. All interviews concluded with a question designed to end the interview on a positive note. Specifically, participants were asked whether any good things occurred because of the trauma they experienced. Consistent with the iterative nature of sampling and analysis in qualitative research, some of the questions were generated from prior interviews and modified as the research progressed (Strauss & Corbin, 1998). For example, some participants articulated frustration at their inability to continue with the activities of daily living such as house maintenance, and I asked them if they felt that this compounded some of their current mental health problems or exacerbated their trauma symptoms.

Upon completion of the interview, participants were debriefed both verbally and in writing. They were asked to provide a pseudonym to be used in the write-up of the findings in order to ensure their anonymity and were given the opportunity to provide feedback on the initial research findings. In order to facilitate accuracy, participants were also asked for permission to call them in the future if I needed to clarify certain points or ask questions I may not have thought of asking during the interview. In addition, participants were asked if they would be willing to provide feedback on a preliminary

summary of the research findings. Participants were then paid \$30 for their participation and were provided with contact information for potential supports in the community and people they could contact regarding the study itself, the ethics of the study, and any other concerns. Finally, participants were given the opportunity to choose a grounding stone from a bag of stones that I provided. They were given a thank you card that explained that grounding stones are used as a reminder of the present. If talking about their experiences brought up unpleasant feelings or memories, participants could hold the stone in their hand to remind themselves of their strength, strength that helped them endure their experiences and share their wisdom with me.

Not surprisingly, given the nature of the interview, the majority of women and men I interviewed were quite emotional during the interview, often crying or having to pause due to the emotional nature of their disclosure. At the end of the interview, I took time to talk to them about “everyday” things such as the weather or ask them what they were going to do after the interview. I also offered to go for walks with them. For one participant (Nadia), who was a very religious woman, I asked her if she wanted me to pray with her. These were all welcomed suggestions which appeared to put participants at ease.

After each interview, I used a Post-Interview Comment Sheet (see Appendix A) to comment on the mood and tone of the overall interview (e.g., “Good rapport with the participant. He seemed comfortable telling me things. He teared up a lot but always stopped himself before he started to cry”); the participant’s emotions during the interview (e.g., “overall, she was quite friendly. She cried a few times but overcame her emotions by using humour, which seemed to put her at ease”); my emotional reactions to the

participant (e.g., “He was a nice man and easy to interact with. He divulged at the end that he was attracted to pre-pubescent girls. This made me feel shocked and disgusted because I didn’t know what to do with it. It made me immediately label him as a “pervert” although I recognize that it took a lot of courage to divulge this information.”); my emotional reactions to what the participant said (e.g., “He started to blame his wife by saying “well, you know, she’s aging badly.” This made me angry so I basically shut down the interview at that point.”); the strong points of the interview (e.g., “really good in-depth discussion of the gendered aspects of trauma, including her current therapy and her openness to it”); the weak points of the interview (e.g., “I didn’t follow-up enough with probes and need to ensure I do so for the next interview”); and any other notable features of the interview (e.g., “Although open to discussion, she didn’t make a lot of eye contact – may just be idiosyncratic.”).

The Posttraumatic Diagnostic Scale

In order to ascertain the rates of PTSD among the sample, participants were also asked to fill out the *Posttraumatic Stress Diagnostic Scale (PDS)*, a brief screening tool that yields a PTSD diagnosis according to *DSM-IV* criteria and assesses symptom severity (Foa, Cashman, Jaycox, & Perry, 1997). The PDS contains 49 items that evaluate participants’ exposure to previous trauma and the extent to which they felt threatened, helpless or terrified. In addition, participants were asked to use 4-point scales ranging from *Not at all or only one time* (0) to *Five or more times a week/almost always* (3) to rate 17 items related to *DSM-IV* PTSD symptoms of re-experiencing (e.g., “Having bad dreams or nightmares about the event,” “Reliving the traumatic event, acting or feeling as if it was happening again”), avoidance (e.g., “Trying not to think about, talk

about, or have feelings about the traumatic event,” “Trying to avoid activities, people, or places that remind you of the traumatic event”) and arousal (e.g., “Being jumpy or easily startled (for example, when someone walks up behind you),” “Feeling irritable or having fits of anger”).

Finally, participants are asked to indicate whether they are experiencing significant impairment in a variety of life areas (e.g., friendship, leisure activities, household duties) within the past month, using a Yes/No format.

The PDS has been identified as one of the best self-report measures of PTSD with an internal consistency of .91 (Adkins, Weathers, McDevitt-Murphy, & Daniels, 2008). The PDS also demonstrates good test-retest reliability. Foa et al. (1993) evaluated the test-retest reliability using data collected from 29 subjects who completed the PDS 9 to 10 weeks after the attack (third assessment) and 12 to 14 weeks post assault (fourth assessment). Test-retest reliability of the overall severity score of the PDS was .74. The re-experiencing subscale had a test-retest reliability of .66, the avoidance subscale was .56, and the arousal scale was .71. The PDS has also consistently demonstrated excellent convergent and concurrent validity (Foa et al., 1993; Foa et al., 1997; Powers, Gillihan, Rosenfield, Jerud & Foa, 2012).

Data Analysis

Two qualitative methods were used to analyze the interview transcripts: grounded theory analysis and discourse analysis. Grounded theory was used to examine the *ontogenic*, *micro-system*, and *exo-system* factors that affected aging trauma survivors' experience of disclosure and help-seeking. Discourse analysis was used to examine the

extent to which *macro-system level factors* (i.e., gender and age-related discourses) also had an effect.

Grounded Theory

Grounded theory is an inductive method of generating theory that is grounded in data (Dey, 1999; Glaser & Strauss, 1967). In grounded theory, the data is coded as it is collected, which entails interacting with the data and posing questions during coding (Charmaz, 2000). As stated by Charmaz (2000, p.15), “unlike quantitative research the researcher’s interpretations of data shape his or her emergent codes.” To this end, I employed a “constant comparative method” (Charmaz, 2000; Fielding & Lee, 1998; Glaser & Strauss, 1967) that entailed : 1) comparing different people (e.g., their views, actions, experiences); 2) comparing data from the same individuals with themselves but at different points in time; 3) comparing incident with incident; 4) comparing data with categories, and; 5) comparing categories with each other (Charmaz, 2000; Dey, 1999).

Grounded theory coding means codes are created as the data is studied (Charmaz, 1995, 2000; Dey, 1999; Strauss & Corbin, 1998) and constant comparisons are made throughout each of three stages of coding: open coding, axial coding and selective coding. During the *open coding* stage, the data was broken down into discrete parts that were closely examined and compared for similarities and differences. This examination allowed for “fine discrimination and differentiation among categories” (Strauss & Corbin, 1998, p. 102). Open coding involved examining the transcribed interviews by

line or paragraph in order to generate a list of concepts (or codes). This helped deter me from imposing preconceived theories or beliefs on the data (Charmaz, 2000).¹⁰

Some of the names given to the concepts are based on the actual words of the participants (referred to as “in vivo coding”) or the wider literature (Straus & Corbin, 1998). As data analysis continued, other objects, events, or acts that were conceptually similar were placed within the same code and eventually, conceptually similar codes were grouped together into categories that were defined in terms of their properties (i.e., their general or specific characteristics) and dimensions (i.e., how the properties vary along a continuum or range; Dey, 1999; Strauss & Corbin, 1998).

The *axial coding* stage involved identifying the relations between categories and subcategories in terms of their properties and dimensions in order to form “more precise and complete explanations about phenomena” (Strauss & Corbin, 1998, p. 124). Procedurally, Strauss (1987, cited in Straus & Corbin, 1998) delineates four basic tasks during axial coding: 1) laying out the properties of a category and their dimensions; 2) identifying the variety of situations, actions and consequences associated with a category; 3) relating a category to its subcategories through statements indicating how they are related (e.g., “as a consequence of *shame about their traumatic experiences* [category], older adults’ are likely to *be reticent to seek help* [subcategory] and feel *unworthy of care* [subcategory]) and; 4) seeking cues in the data that illustrate how major categories may be related to each other. This was accomplished by asking questions about the data, such as who, what, where, when, and why or how. It was also facilitated by considering

¹⁰ Throughout the coding stages, I used memos and maintained a methodological reflexivity journal to record decisions that were made about the interview questions, the sampling and the analysis (Strauss & Corbin, 1998).

participants' language, including looking for language reflective of causality such as "because," "therefore" and "so."

A major component of axial coding is the identification of negative cases. Negative cases (or, in quantitative terms, outliers) are cases that seem to contradict the emerging theory. However, negative cases do not necessarily serve as contradictions. Rather, they may suggest that emerging ideas need to be modified (e.g., by adding dimensions to categories) and encourage the identification of factors (e.g., aspects of the person or situation) that may moderate the observed relations (Marshall & Rossman, 1995; Seale, 1999; Strauss & Corbin, 1998). For example, as described later in the results section, although some participants indicated experiencing traumas such as war and concentration camps, they did not all experience poor psychological outcomes. As a result, I examined the qualities of their experiences and found that these negative cases could be explained by the sense of "collectivity" related to these traumas (i.e., a sharing of similar experiences with others) and for others, a sense of normalcy. In the context of help-seeking and disclosure, it appears that these elements can ameliorate some of the deleterious effects of these traumas on people's well-being via their willingness or need to talk about their trauma.

Finally, the *selective coding* stage involved identifying the core category and refining the emerging theory, which represents the main theme of the research (Strauss & Corbin, 1998). A number of criteria guided the selection of a central or core category: 1) all major categories were related to it; 2) within almost all cases, the data pointed to this concept; 3) the explanation of the relation between categories was logical and consistent; 4) the core category was sufficiently abstract to be used in other substantive areas and

lead to the creation of a more general theory; 5) the theory grew in depth and explanatory power as the concept was refined through integration with other concepts; and 6) the core category was able to explain the main point of the data as well as variation and potential alternative explanations.

Iterative sampling and analysis. Using an iterative design, I slightly revised the interview guide so that it included questions that explored and probed the concepts or themes that emerged from the analysis of earlier interviews. For example, I started to ask questions about additional constraints experienced by the participants that could explain some of their current problems (e.g., physical/psychological constraints). In addition, my iterative analysis also led to *theoretical sampling*, which refers to sampling based on the need for a particular experience and/or knowledge (Dey, 1999; Strauss & Corbin, 1998). The aim of theoretical sampling is to maximize opportunities to compare events or incidents in order to identify the properties and dimensions of a category. Because I was directed by the evolving theory, my sampling became increasingly more specific. This enabled me to define categories, differentiate among them, specify their range and, as a result, identify their interrelations. According to Strauss and Corbin (1998), “theoretical sampling is important when exploring new or uncharted areas because it enables the researcher to choose those avenues of sampling that can bring about the greatest theoretical return” (p. 202). For example, during my analysis the issue of “a sense of normalcy” seemed to play a large role in participants’ disclosure of their trauma and the long-term psychological effects of their traumatic experiences. As such, I decided to interview people who experienced non-interpersonal traumas, such as those related to

illness and death of loved ones. This helped me further explore the concept of 'normalcy' as determining factors in participants' willingness to disclose or seek-help.

Moreover, as certain discourses began to emerge from the interviews, I specifically started asking participants about them. For example, "As a man, did you feel that it was difficult for you to show emotion?" I continued this iterative process of revising interview questions, sampling and analysis until theoretical saturation, or at least theoretical sufficiency (Dey, 1999), was achieved. That is, until no new categories emerged, each category's properties and dimensions were fully developed (i.e., density was achieved) and demonstrated variation, and the relations among the categories are established (Strauss & Corbin, 1998). This occurred after the 14th interview.

Discourse Analysis

The interview data was also analyzed using Discourse Analysis in Social Psychology (DASP; Potter & Wetherell, 1997; Wood & Kroger, 2000), a form of analysis that is sensitive to the range, variation and complexity of people's accounts or discourses. Using this method, I conducted a close analysis of participants' talk, focusing on their discursive practices and the meanings they ascribed to them (Wood & Kroger, 2000). Hence, the grounded theory analysis examined the content of participants' narratives (i.e., *what* they said), whereas the discourse analysis examined process (i.e., *how* they said it; Holstein & Gubrium, 1995).

Major components of discourse analysis include *function*, *construction* and *variation* (Potter & Wetherell, 1987; Wood & Kroger, 2000). *Function*, or action, refers to the use of language to do things (e.g., to order, to request, to persuade), in particular, what people are doing with their talk and text. Essentially, function refers to language as

action and can be viewed in terms of what talk is about, what the speaker does with it, and the effects of the talk on the hearer. For example, one participant said “Well there’s nothing you can do about that, you’re just getting old.” This statement not only describes a conversation or event, it also suggests to the hearer that any attempt to help themselves would be a waste of time. *Construction* refers to analyzing how people use language to construct particular versions of the social world. For example, referring to “rape” as “intercourse” leads to a particular understanding of the sexual assault. Specifically, it implies consent on the part of the victim and, as a result, holds them responsible for their assault. This formulation, in turn, can lead to a construction of one person’s particular reality. Finally, *variation* refers to the variability in people’s accounts that occurs as people construct their accounts using language suited for different purposes, audiences and occasions. For example, examination of the variation in participants’ accounts revealed that women and men drew on very different discourses when discussing their traumatic experiences, disclosure and help-seeking. Essentially, variation in discourse analysis operates like negative cases in grounded theory in that both challenge and thereby help to modify the emerging findings (e.g., by encouraging the identification of moderating factors; Marshall & Rossman, 1995; Potter & Wetherell, 1987; Seale, 1999; Wood & Kroger, 2000).

In discourse analysis, the dialogue during an interview produces one possible version, account or subjective experience of events. Thus, an “active” interview is required in which the interviewer and participant are engaged in “conversational encounters” (Wood & Kroger, 2000, p. 72; see also Holstrein & Gubrium, 1995) whereby the interviewer actively probes for responses around the participants’ views and the

participants' interpretive resources are explored (Potter & Wetherell, 1987). Thus, the discourses older adult trauma survivors refer to in the course of talking about their traumatic experiences and aging created an "account" of their experiences that was explored. During this stage of analysis, I searched for broad discourses that the participants drew upon to explain their experiences. Specifically, major categories of the interviews were identified and analyzed to find patterns of similarity and variability in accounts both within and across participants (as described under "grounded theory") and the discursive strategies used in the construction of these accounts were identified (Wood & Rennie, 1994). For example, some of the male participants who had been sexually abused as children indicated that they did not disclose their abuse for fear of being labelled a homosexual. Thus, discourses of homophobia played an important part in their understanding of their experiences and their willingness to seek help.

Discourse analysis can give coherence to institutional structures of power and ideology (e.g., ageism) and how they may affect older adult trauma survivors. Thus, participants' actual use of language was analyzed in order to discern main patterns of discourse and to describe the function, construction and variation in the linguistic resources older adults use in formulating their experiences of trauma.

The first stage of coding in discourse analysis is selective coding, which simply involves reducing the data into manageable, analytical chunks such as sentences, instances or paragraphs (Potter & Wetherell, 1987). In addition, the categories used in coding are related to the research questions of interest. For example, in the current study, the purpose of the discourse analysis was to examine whether and how older adult trauma survivors use discourses around aging and gender to construct their experiences of trauma

and the implication of these discourses for older adults' disclosure and help-seeking behaviour. Thus, I actively sought to identify discourses related to aging and gender throughout the coding stage.

The analysis consisted of two stages. First, as in grounded theory, I searched for patterns of meaning in the data. In doing so, I searched for both variability and consistency between and within participants' accounts (Potter & Wetherell, 1987). For example, I started with the account of the same event (e.g., disclosure or non-disclosure of trauma) across different participants. The second phase of analysis involved forming hypotheses about the functions and effects of using certain discursive strategies and finding linguistic evidence that speaks for or against those hypotheses. For example, in their study of discourse and rape, Wood and Rennie (1994) illustrated the many ways that women drew on discourses related to rape in order to negotiate identities for themselves as victims or non-victims. As with grounded theory, this stage also involved actively examining the data for alternative explanations and exceptions (e.g., instances where participants did not draw on discourses regarding gender).

Research Quality

It is often suggested that qualitative research is less rigorous than quantitative research, however, when done correctly, qualitative research is no less rigorous (Potter & Wetherell, 1987; Rice & Ezzy, 1999). Indeed, both qualitative and quantitative researchers strive to enhance the truth value, consistency, neutrality and applicability of their findings. Within qualitative research, however, these concepts have been referred to in different ways, namely; credibility (vs. internal validity in quantitative research), dependability (vs. reliability), confirmability (vs. objectivity) and transferability (vs.

external validity). Unlike quantitative, positivist and post-positivist guided researchers, qualitative researchers also strive for *authenticity* (Lincoln & Guba, 1985; Seale, 1999). Within discourse analysis, these concepts are included under the umbrella of *warrantability*. Warranting refers to illustrating that the analysis is sound and based on evidence that is supportive, acceptable and convincing. Criteria for warranting are the criteria of trustworthiness (i.e., dependability) and soundness (i.e., credibility) and are achieved using the same strategies as other qualitative research methods (Wood & Kroger, 2000).

There has been ongoing debate among qualitative researchers regarding the benefits of forcing positivist criteria of validity and reliability onto qualitative research (Morrow, 2005; Seale, 1999; Wood & Kroger, 2000). In particular, staunch proponents of social constructionism view efforts to achieve reliability as promoting artificial consensus (for a review see Seale, 1999). Many of these arguments stem primarily from ideological differences between positivists, who believe there is an objective truth, and social constructionists, who believe there are multiple, subjective realities (Burr, 1995; Parker, 1994). As argued by Morrow (2005, p. 252),

As long as qualitative researchers are apologetic for our unique frames of reference and standards of goodness, we perpetuate an attitude on the part of postpositivist researchers that we are not quite rigorous enough and that what we do is not “real science.”

Although some of the criteria for qualitative research quality were initially developed using traditional, positivist or post-positivist frameworks, like Seale (1999), I believe the techniques for achieving these criteria can facilitate the quality of qualitative research. Similarly, although Wood and Kroger (2000) believe that qualitative

researchers should not regard validity in terms of the idea of ‘truth’ as put forward by positivists, they do urge qualitative researchers to attend to other meanings of the term validity, meanings that emphasize that our analyses are sound, well grounded, and based on convincing evidence. That being said, throughout the following discussion, I present both the pros and cons of such techniques or approaches to facilitating the quality of qualitative research. By doing so, I hope “to demonstrate an educated awareness of the consequences of particular methodological decisions during a research study, whether they relate to the production of data or the choice of writing style” (Seale, 1999, p. 33).

Credibility. In qualitative research, credibility refers to the believability of the findings and evidence that the research findings provide an accurate account of participants’ dialogue and meanings. There are a number of ways of enhancing the credibility of qualitative research, including the use of semi-structured in-depth interviews (i.e., interviews that are long enough to generate good data and vary in length as a function of the interviewees’ knowledge, verbal skills and needs; Kvale, 1996), devoting attention to how social contexts affect the phenomenon under investigation, using iterative sampling and systematic analysis of the data, and deliberately looking for and considering negative cases. The credibility of qualitative research can also be facilitated by triangulation, testing the emergent model with uncoded data, presenting supportive quotes, and making clear distinctions between data and interpretation (Lincoln & Guba, 1985; Potter & Wetherell, 1987; Seale, 1999; Strauss & Corbin, 1998).

According to post-positivism, triangulation is used to ensure that there is a convergence of findings (i.e., that various methods and data sources point to the same conclusion). However, within social constructionism, triangulation is used to increase the

breadth and depth of the research findings and achieve a more comprehensive, integrated understanding. It involves collecting information from a variety of different sources in order to identify the most comprehensive account of an event or phenomenon (Potter & Wetherell, 1987). There are four types of triangulation that can be used to enhance this breadth (Seale, 1999). *Data triangulation* involves obtaining data from various people, in various settings, at various times, and in various places, and facilitates the consideration of multiple participant perspectives. *Investigator triangulation* involves having multiple researchers conduct the observations, interviews, and/or analyses. This type of triangulation facilitates the emergence of various points of view that allow for the exploration of alternative or more complete views of the data. Similarly, *theory triangulation* involves the researcher considering the data from different theoretical perspectives. Finally, *triangulation of method* involves using multiple methods to obtain data, such as a combination of interviews, observations and/or surveys.

There are a number of criticisms of this approach to ensuring “credibility” of one’s research. For example, for discourse analysts, there is considerable variation in accounts. Indeed, even one individual can give two different accounts of the same event (Wood & Kroger, 2000). Thus, discursive data from a number of sources may actually *compound* the variability between participants’ claims, rather than reduce it. According to Potter and Wetherell (1987), although variation is important, triangulation may make the data unmanageable, particular with regard to discourse analysis. In addition, other qualitative researchers contend that the use of triangulation is inconsistent with the theoretical foundation of qualitative research and can only make sense within a positivist framework (for a review see Seale, 1999). However, if triangulation is used to expand

the depth and breadth of the research findings, rather than as a tool to verify one “truth,” then providing various sources of evidence enhances credibility in a way that is consistent with the philosophy of science underlying social constructionism (Seale, 1999).

In light of this, triangulation of theory and methods of analysis (i.e., grounded theory and discourse analysis) were used in this study. Triangulation of theory was used to ensure that I explored various alternative explanations of the experiences of older adult women and men trauma survivors. These are evident in both the introduction and discussion section. I also used two different methods of analysis in order to examine the varying levels of factors that can affect aging trauma survivors’ experience of trauma and disclosure and help-seeking, including personal factors and social discourses regarding gender and aging.

Another way of enhancing credibility is to test the findings with uncoded or new data. Testing with uncoded data involves setting aside a portion of data to later verify the applicability of conclusions. Alternatively, new data can be used to verify findings from the original analysis (Seale, 1999). This process essentially allows the researcher to double check the findings (Huberman & Miles, 1994). To the extent that I found that theoretical saturation was achieved after the fourteenth interview, given my analysis, the three remaining interviews provided the opportunity for me to increase the breadth and depth of my understanding of the data.

The presentation of supportive, informative and extensive quotes also enhances the credibility of the research findings. In essence, quotes should provide examples that clearly illustrate the researcher’s arguments (with at least one quote for secondary parts

of the argument and two or more good, illustrative quotes for major points; Rubin & Rubin, 1995). Following directly from the presentation of supportive quotes, credibility is also enhanced when the reader is able to distinguish the data from the researcher's inferences and interpretations of the data (Popay, Rogers, & Williams, 1998; Seale, 1999). Hence, I endeavoured to make clear the distinction between what participants actually said and my inferences. Discourse analysts refer to this as *demonstration*, whereby both interpretations of individual excerpts and overall claims are grounded in the text (Wood & Kroger, 2000).

Throughout the current research and as illustrated in the results section, efforts were made to ensure that I adhered to these components of credibility, thus enhancing the depth, believability and accuracy of the findings.

Dependability. Another important criterion for assessing the quality of qualitative research is dependability, which essentially refers to the replicability of the study and the reliability of its methods (Lincoln & Guba, 1985; Seale, 1999). In qualitative research, the ability to replicate is accomplished by providing an audit trail for other researchers who may wish to replicate this study.

Postmodern or constructivist critiques of the "replicability" of qualitative research assert that, because multiple realities are possible, replicating accounts is not regarded as appropriate (Potter & Wetherell, 1987; Seale, 1999; Wood & Kroger, 2000). Discourse analysts in particular argue that, because there is no single, correct response, the repetition of results is as much an indication of the similarity between the procedures and assumptions of the researchers as it is of the existence of a particular phenomenon (Wood & Kroger, 2000). However, because an audit trail involves "exhaustive accounting and

evidence-checking procedures ... [that] promote a culture of self-criticism and fallibilism" (Seale, 1999, p. 144), this technique can illustrate the soundness of the research. In light of this, I maintained a reflexive account of the methods and methodological decisions in a methodological reflexive journal (to record decisions about interview questions, sampling and analysis) and memos (to record decisions throughout the analysis).

Confirmability. A third evaluative criterion, confirmability, is facilitated by evidence that the researcher has monitored and attended to their biases and assumptions and how they may affect the research process and outcomes (Seale, 1999). Although post-positivists may use strategies such as using external auditors in order to minimize this bias, social constructionists acknowledge the role that the researcher plays in constructing meaning and interpreting the data (Morrow, 2005).

Monitoring and attending to biases is addressed by the researcher maintaining a self-reflexive journal or personal audit trail in which they note and consider their expectations, assumptions, personal reactions, etc. The criterion of confirmability is premised on the idea that being aware of personal biases will enable the researcher to be at least somewhat aware of their potential influence on the analysis (Seale, 1999). Because one's interests, values, and beliefs can influence the research process (Tindall, 1994), documenting these influences can help readers evaluate the quality of my conclusions. In order to reduce the influence of my biases, I maintained a self-reflexive journal in which I noted my assumptions and personal reactions. For example, when I first started interviewing male sexual abuse survivors, I assumed that issues of powerlessness would not necessarily affect them, given their higher status in society.

This assumption was, in fact, incorrect, in that powerlessness played a strong role in how male sexual abuse survivors felt about talking about their abuse and their willingness to disclose and/or seek help for their abuse. As a result, I endeavoured to delve into the notion of powerlessness with male participants.

In addition to the self-reflexive journal, I also completed a Post-Interview Comment form immediately following each interview in order to note my own emotions and reactions throughout the interview process. This allowed me the opportunity, to the extent possible, to be aware of the possible impact of my own biases on the analysis and emerging theory. By commenting on the strong and weak points of the interview, these post-interview comments also facilitated reflecting on ways of improving subsequent interviews.

Transferability. Because qualitative researchers are interested in sampling meaning, they do not strive to obtain a representative sample of the population and are not concerned with external validity in the positivist sense. Instead, they seek to sample diverse meanings and perspectives and sample until there is evidence of such diversity. Qualitative researchers are, however, concerned with the transferability of the findings, and I have therefore provided detailed descriptions of both the participants and their settings so that research consumers can assess the applicability of my findings to other settings or people.

Authenticity. In an attempt to address the much debated paradox of trying to apply criteria to “multiple constructed realities” (Seale, 1999), Lincoln and Guba (2000) suggested another criterion for evaluating the quality of qualitative research, namely authenticity. Authenticity has its roots in social constructionism and is comprised of five

components: fairness, ontological authenticity, educative authenticity, catalytic authenticity, and tactical authenticity. *Fairness* is demonstrated when the researcher shows that a range of different realities has been represented and there have been deliberate attempts to avoid marginalization. *Ontological authenticity* refers to the ability of the research to develop a better or more complete understanding of the phenomenon being studied. *Educative authenticity* refers to participants' increased awareness and appreciation of the viewpoints of others. *Catalytic authenticity* refers to the extent to which the research stimulates action on the part of research participants. Finally, *tactical authenticity* refers to the use of the research to involve participants in social and political actions. Throughout the current research, I endeavored to include participants with different backgrounds (e.g., trauma experiences, ethnicity) and to ensure that all participants were represented within the analysis (i.e., *fairness*). I also hope that this research will contribute to a more comprehensive understanding of older adults' experiences of the aftereffects of trauma, disclosure and help-seeking (i.e., *ontological authenticity*). Finally, I would argue that this research project had at least some *catalytic authenticity*. This was illustrated by the participant Braveheart, a male sexual and physical abuse survivor who, as a result of his participation, decided to write a book about his experiences (which I had the opportunity to review). In addition, he submitted an article on his experience to a popular mental health magazine and discussed the possibility of starting an older men's self-help group.

To the extent possible, I have strived to enhance the quality of my research through the various means outlined above. As articulated by Seale (1999; p. 49):

...exposure to any well thought-out methodological discussion, from whatever tradition, is likely to increase a desirable aspect of research

practice: methodological awareness. If there is one thing that produces poor studies, it is a researcher who is blind to the methodological consequences of research decisions.

Results

In this section, I will present the results of the two types of analysis: grounded theory analysis and discourse analysis. The grounded theory analysis involved examining the factors that affected participants' willingness to disclose their traumatic experiences or seek help for their trauma-related problems. These findings are organized as a function of time, that is, whether the experiences of disclosure or help-seeking occurred during childhood or as an adult. In the discourse analysis section, I present the findings regarding the discourses that may have played a role in inhibiting participants' disclosure or help-seeking behaviour, thereby providing a wider socio-cultural context for understanding the participants' experiences.

Participants

The 16 participants in this study generated almost 40 hours of interview data. Despite the often gut-wrenching emotion that recalling memories of their traumatic past evoked, the women and men who took part in this study were incredibly honest and open about their experiences. This was particularly remarkable given that a number of participants said that they had not talked to someone about their trauma experiences in almost 60 years, while others had never disclosed their traumatic experiences to anyone.

As shown in Table 1, which lists the participants' demographic characteristics, the 16 participants consisted of eight women and eight men between 61 to 83 years of age (*M age* = 70.0 years). Although all of the participants were Caucasian, they represented a range of nationalities: two were British, one was Lebanese, one was Indonesian/Dutch, one was Hungarian and one was German. The rest described themselves as either Canadian or French Canadian. Twelve of the participants indicated that they were

divorced, widowed or separated, and four were either married or living in common-law relationships. The level of education varied considerably among the participants. Eight of the participants indicated having a high school education (with some not obtaining their high school diploma) and eight had a college or university degree. Moreover, although all of the participants were retired, their previous occupations also varied considerably (see Table 1).

As shown in Table 2, the participants experienced a range of traumas during childhood, including sexual abuse (by a family member or stranger), physical abuse (by family members), emotional abuse (by parents), neglect (by parents), internment in a work camp during World War II, and warfare (for more information see Appendix B, which contains profiles for each participant, as well as information regarding their traumatic past).

Finally, eight of the participants met the clinical cut-offs for PTSD¹¹ as measured by the *Posttraumatic Diagnostic Scale*. Interestingly, only three of the participants (Braveheart, Indigo and Susan) indicated that they had been officially diagnosed with PTSD. These participants were also classified as having PTSD based on the PDS. In addition, 10 participants indicated that they were experiencing other mental health problems such as anxiety, depression, obsessive compulsive disorder and suicidal ideation. Moreover, all but three of the participants suffered from at least one physical ailment, ailments that included arthritis, high blood pressure, high cholesterol, diabetes, irritable bowel syndrome and cardio-obstructive pulmonary disease.

¹¹ Two of the participants (Daisy and Noah) did not return their PDS questionnaire, so information regarding their PTSD status is unavailable. However, during the interview, they did not indicate that they were experiencing any mental health problems.

Table 1

Participants' Demographic Characteristics

Pseudonym	Age	Gender ^a	Country of origin/ethnicity	Relationship status	Children	Education	Employment ^b
Braveheart	64	M	Canadian	Divorced/single	2	B.A. (University)	Stockbroker/entrepreneur
Cinderella	66	F	French Canadian	Divorced/single	3	University (Undergraduate)	Social worker
Daisy	61	F	Canadian	Divorced/dating	3	High School Diploma	Taxi dispatcher/school bus driver
Gung Ho	66	M	Canadian	Divorced/dating	3	University (Graduate)	Economist/university lecturer
Indigo	62	M	French Canadian	Married	1	University (Graduate)	Civil servant
Lily	70	F	Canadian	Married	8	College Degree	Civil servant
Lucky	72	M	Canadian	Separated/single	10	University (Undergraduate)	Personal trainer/private security

Table 1 (con't)

Pseudonym	Age	Gender ^a	Country of origin/ethnicity	Relationship status	Children	Education	Employment ^b
Michael	79	M	British	Common-law	2	High school	Entrepreneur/ restaurateur
Nadia	78	F	Lebanese	Widowed	3	High school	Restaurant owner/operator
Noah	83	M	Hungarian	Widowed	1	Some high school	Art Gallery owner/operator
Penny	74	F	British	Widowed	7	High School	Homemaker
Peter	78	M	Indonesia/Dutch	Divorced	8	University Degree	Church pastor
Quasimodo	63	M	French Canadian	Married	1	Grade 10	Carpenter
Ruth	63	F	Canadian	Widowed	4	Grade 10	Homemaker
Susan	72	F	Canadian	Married	2	B.A. (university)	School teacher
Tulip	65	F	German/Canadian	Divorced	1	Grade 11	Administration, real estate

^aF = female; M = male. ^bAll of the participants were retired at the time the study took place.

Table 2

Participants' Trauma Histories and Current Mental and Physical Well-Being

Name	Trauma	PTSD	Depression	Other mental health problems	Physical problems
Braveheart	Childhood sexual, physical and emotional abuse	Yes ^a	No	OCD, anxiety	Osteoarthritis, deteriorating discs
Cinderella	Childhood sexual and emotional abuse	Yes	Yes	Anxiety, Borderline Personality Disorder	High blood pressure, osteoarthritis, respiratory problems
Daisy	Childhood physical and emotional abuse, Partner abuse	N/A	No	No	Borderline diabetes, osteoporosis, high cholesterol
Gung Ho	Multiple deaths, Divorce	No	No	Possible Bipolar Disorder	None
Indigo	Childhood physical abuse, Neglect	Yes ^a	Yes	Anxiety, dementia	Acquired brain injury
Lily	Attempted rape	No	No	No	High cholesterol
Lucky	Life-threatening illness as a child	No	No	No	None
Michael	Childhood molestation and physical abuse, Warfare	No	No	No	Arthritis

Table 2 (con't)

Name	Trauma	PTSD	Depression	Other mental health problems	Physical problems
Nadia	Childhood sexual abuse	No	Yes	No	None
Noah	Holocaust survivor, concentration camp	No	No	No	Cancer survivor, heart issues
Penny	Warfare, Critically ill child	No	No	No	High blood pressure, acid reflux disease, diverticulitis
Peter	Concentration camp	Yes	Yes	Suicidal, anxiety	18 surgeries on knees and hips
Quasimodo	Childhood sexual and physical abuse	Yes	Yes	Anxiety	Prostate cancer, diabetes, high blood pressure, arthritis
Ruth	Childhood sexual and physical abuse, Death of spouse	Yes	Yes	Anxiety, agoraphobia, panic attacks	High blood pressure, high cholesterol, pace maker
Susan	Childhood sexual abuse, neglect	Yes ^a	Yes	Dissociation	Irritable Bowel Syndrome
Tulip	Childhood sexual abuse, Partner abuse, Alcoholic parents	Yes	Yes	Suicidal, anxiety	Chronic Obstructive Pulmonary Disease, rheumatoid arthritis

^aOnly three participants indicated that they had been officially diagnosed with PTSD; the others are based on PDS scores.

In terms of disclosure and help-seeking, nine participants indicated they had disclosed or sought help for their trauma either immediately after the traumatic event or in early adulthood, four disclosed/sought help in late life as older adults and two had never disclosed or sought help (see Table 3). Of the nine participants who had disclosed/sought help when they were young, six reported negative experiences, including the denial of their abuse, being ignored and having their experience minimized. In addition, four of the participants indicated that, at the time of the interview, they were in therapy to address issues related to their traumatic past.

Grounded Theory Analysis

The grounded theory analysis revealed that older adults' decisions to disclose traumatic experiences or seek help for trauma-related problems were complex and can be understood against a backdrop of a number of interacting factors. During childhood some participants did not disclose their traumatic experiences because of their feelings of shame and fear that resulted from the trauma. The analysis also revealed that early disclosure experiences could either exacerbate or mitigate any feelings of fear or shame. Specifically, participants who felt that they could talk freely about their trauma did not have persistent feelings of shame or fear and went on to live relatively healthy lives. However, participants who experienced a negative reaction to their disclosure of their traumatisation, either through their inability to talk about it or having their disclosure rebuked or disbelieved, had their feelings of shame and fear reinforced. This reinforcement resulted in participants' living with an inability to disclose or seek help throughout their lifetime and this, in turn, led to psychological problems such as PTSD

Table 3

Summary of Participants' Disclosure and Help-Seeking Behaviour

	Childhood		Adulthood		Older Adulthood	
	Disclosure	Help-seeking	Disclosure	Help-seeking	Disclosure ^a	Help-seeking
Braveheart	-ve				X	X
Cinderella				X	X	
Daisy			X		X	
Gung Ho	+ve				X	X
Indigo			X	X		X
Lily					X	
Lucky			X		X	
Michael			X		X	
Nadia	+ve					
Noah			X		X	
Penny	+ve					
Peter	-ve				X	
Quasimodo	-ve		X	X		
Ruth	-ve		X	X		
Susan	-ve		X	X	X	X
Tulip	-ve			X	X	

^aIndicates those participants who disclosed in older adulthood before taking part in the interview.

and ongoing physical ailments. Figure 1 provides an outline of trauma survivors' struggles with disclosure and help-seeking across the lifespan. Other participants did not disclose their traumas because they viewed them as "normal," "everyday" experiences.

In adulthood, reasons for nondisclosure included persistent feelings of shame and fear, but also became more complex as a result of their negative disclosure experiences in childhood. Specifically, their reasons for nondisclosure expanded to include their expectation that their trauma-related experiences would be minimized. Consistent with this, none of the participants reported seeking any sort of professional help (e.g., from family doctors, psychologists, or psychiatrists) for issues associated with or stemming from their childhood traumas. Indeed, participants said they were unaware that any of their problems stemmed from their traumatic past and therefore did not seek therapy for trauma-related problems. However, many participants indicated that they did seek or receive help from professionals for problems they regarded as unrelated to their traumas, such as marital difficulties or panic attacks. As a result, this therapy was not focused on their traumatic past, which, according to participants, was actually the crux of their problems.

The grounded theory analysis also revealed that these patterns of nondisclosure and help-seeking (or lack thereof) persisted well into the participants' senior years. Fear and shame again played a pivotal role in many participants' decisions regarding disclosure as did the persistent effects of a negative disclosure experience as a child, which in some cases were further compounded by negative disclosure experiences as adults. As older adults, participants' reasons for not seeking help for their trauma-related difficulties also changed, becoming deeply entrenched in feelings of disillusionment with

Figure 1. *Trauma Survivors' Struggles with Disclosure and Help-Seeking Across the Lifespan*

therapy and a tendency to steer the focus of their help-seeking to the physical rather than psychological aspects of their health, as well as ongoing distrust stemming from their earlier traumatic experiences.

Childhood – The Dynamics of Disclosure

The majority of participants indicated that, as children, they were reluctant to talk to anyone about their trauma. This was particularly true of those who experienced physical and/or sexual abuse. They discussed a number of reasons for this, including shame, fear and their perception that what they were experiencing was “status quo.”

Shame

Not surprisingly given the nature of the trauma experienced by the participants, particularly trauma associated with physical and sexual abuse, many women and men felt ashamed of their experiences (Table 4 provides information on where participants stood for each category). This shame, in turn, inhibited their ability or willingness to disclose or discuss their trauma at the time it occurred. These feelings of shame were varied and nuanced for each of the participants.

For Nadia, a 78-old-woman who was sexually abused as a child, the feelings of shame were deeply entrenched in Lebanese cultural values regarding virginity and marriage. She described how she did not feel ashamed when she was being sexually abused between the ages of five and six years old. For her, the shame came a number of years later when, as an adolescent, she started to understand the possible repercussions of her sexual abuse on her virginity. Nadia’s shame stemmed from her belief that she was “damaged goods” and she would not be able to accept an offer of marriage: “I did not feel ashamed then [as a child]. I felt ashamed when the people start coming to ask for my

hand in marriage [as an adolescent]. I don't want to marry anybody and I was a very good looking woman."

When asked why she would not marry, Nadia explained:

I kept telling them that because one day I was sitting and there was two ladies making bread and they were talking about one girl. Somebody attack her, and bleed her, and things like that and that when she gets married her husband will divorce her. So that came, like I was about 12, 13, maybe I'm not sure, about 15. So I heard them talking like that and that weigh heavy on me. Any time that somebody ask for my hand for marriage, I say "No, no, no, I don't want to" (...) ¹² I was like ashamed. I grew up thinking I was terrible. All that time from the age of 7 until the time I told my mother I was always kind of depressed and thinking and especially when people come and ask my dad for marriage.

Some participants who were survivors of sexual and/or physical abuse experienced shame because they believed that they were somehow responsible for the trauma. This made it difficult for them to talk about their abuse. For example, Susan, a 72-year-old woman who was sexually abused as a child, indicated that no one ever talked about her having been raped by a neighbour at the age of three. "At the time [when she ran home and told her parents] what happened was everyone focused on my dad. Nobody ever talked to me about it afterwards. Nobody. It was another one of those 'don't speak about it things'." Susan explained how she was affected by being neglected and not having her rape discussed or her feelings stemming from the rape addressed:

Well the main effect was that when I said I was scared, I was told there is nothing to be scared of. When, you weren't allowed to be angry, so that was all suppressed. So I ended up feeling as though I was worthless because what I was

¹² (...) indicates that some talk was omitted from the data segment.

telling the world wasn't acceptable. What I said wasn't true. So then I must be wrong and bad.

Michael, a 79-year-old man who was molested by his father as an adolescent, discussed feeling ashamed and not wanting his family's reputation to be hurt: "No, I was ashamed...because I didn't want people to think bad things about our family unit. I didn't want to discuss it." Michael went on to further explain that, as a gay man, he was also worried about people finding out about his sexuality, "Because I was still incredibly in the closet. I didn't want to talk about my feelings, that side of my life to anybody.

Peter, a 78-year-old man of Dutch origin who was incarcerated in a concentration camp in Indonesia during the Second World War (occupied by Japan) from the age of 11 to 14, also reported feelings of shame. However, his shame stemmed from his feelings of guilt around the fact that the Dutch, who had colonized Indonesia, had been discriminatory toward Indonesians. Thus, he believed his incarceration in a prison camp was somehow deserved because the "conquerors" had become the "conquered." This played a very large role in his unwillingness to talk about his traumatic experiences in the camp:

I didn't dare to talk about my past. Well, you know. I felt guilty and I could understand the Indians and all the Aborigines, in the same way as we had, uh ... been discriminatory to them, the Indonesians.

Interestingly, when I asked Ruth follow-up questions regarding feelings of shame, she very clearly stated that shame did not play a role in her (un)willingness to disclose:

No, because I didn't do anything to cause it and I knew that. This was totally on the adults as far as I'm concerned. Totally on the adults. I'm a little kid. Adults shouldn't be doing this. We were taught about don't talk to strangers in schools.

Table 4

Categorization of Participants' Reasons for Non-Disclosure

Participant	Childhood Trauma	Childhood				Adulthood			Older Adulthood
		Shame	Fear	Sense of normalcy	Negative reaction to initial disclosure	Shame	Fear	Expectation that experience would be minimized	Persistent feelings of shame and fear
Braveheart	Sexual, physical, & emotional abuse	high	high	low	yes	high	high	high	high
Cinderella	Sexual & emotional abuse	high	high	low	no	high	high	low	low
Daisy	Physical & emotional abuse	low	high	high	no	low	high	low	low
Gung Ho	Multiple deaths	low	low	high	no	low	low	low	low
Indigo	Physical abuse, Neglect	low	high	low	no	low	high	low	low
Lily	Attempted rape	low	low	low	no	low	high	low	low
Lucky	Life-threatening illness	low	high	high	no	low	low	low	low

Table 4 (con't)

Participant	Childhood Trauma	Childhood				Adulthood			Older Adulthood
		Shame	Fear	Sense of normalcy	Negative reaction to initial disclosure	Shame	Fear	Expectation that experience would be minimized	Persistent feelings of shame and fear
Michael	Molestation, physical abuse, Warfare	high	high	high	no	low	low	low	low
Nadia	Sexual abuse	high	high	low	no	low	low	low	low
Noah	Concentration camp	low	low	high	no	low	low	low	low
Penny	Warfare	low	low	high	no	low	low	low	high
Peter	Concentration camp	high	high	low	yes	high	high	high	high
Quasimodo	Sexual & physical abuse	high	high	low	yes	high	high	high	high
Ruth	Sexual & physical abuse	low	high	low	yes	low	low	high	high
Susan	Sexual abuse & neglect	high	low	low	yes	high	high	high	high
Tulip	Sexual abuse	low	low	high	yes	high	high	high	high

So when this guy started doing this, I knew it was wrong, right? No. Why should I feel ashamed? Never. Never.

As discussed later in the section on negative disclosure experiences, Ruth was more profoundly affected by the disbelief of her disclosure of abuse.

To summarize, shame was a large impediment to many participants' ability to talk about their trauma or disclose it to a person who could in some way stop the abuse or help them with their trauma-related problems. That sexual and physical abuse survivors' feelings of shame are entrenched in socio-cultural mores around sex and sexuality is not surprising given the general perception from their generation that sex was not something to be talked about openly. For these senior survivors, a stark gender difference was evident in men's and women's feelings of shame. Specifically, of the women who indicated that shame played a large role in their inability to discuss their abuse, their description of shame is entrenched in feelings of self-blame. Men's shame, in contrast, appears to be entrenched in feelings of inferiority. These notions will be examined further in the discourse analysis section of this paper. Furthermore, participants who experienced trauma such as deaths of loved ones, illness or, in Noah's case, the Holocaust, did not describe shame as impeding their ability to talk about their trauma. These differences will be discussed in more detail in the section related to people's perception of the "normalcy" of their traumatic experiences.

Fear

Many participants indicated that, as children, feelings of fear impeded their ability to talk about their traumatic experiences. These feelings of fear were linked to their perception that disclosure of trauma would diminish how others would view them. For example, they feared being held responsible for the trauma or being perceived as inferior.

Cinderella, a 66-year-old woman who was sexually and physically abused as child, discussed how she did not tell anyone about the sexual abuse when she was younger for fear of being blamed or rejected:

No, I didn't want to tell to anybody because I didn't know what the reaction would be. Maybe they would have been blaming me. Maybe they would have been rejecting me. Maybe they would have been hating me, maybe, you know, that type of thing.

Cinderella also explained why she specifically did not tell her mother: "My mother and I, we never got along well and then if I would have been saying something to her I would have been the one blamed that I was responsible."

Lucky, a 72-year-old man who survived a life-threatening illness (Guillain-Barré syndrome) as a child discussed how his feelings of fear were related to feeling inferior: "Because it was secret and private and in the past and bringing it up might be an admission of, I think, inferiority. And so it was never mentioned."

When asked if her decision to not disclose her uncle's attempt to molest her when she was 13 was a result of being worried about other people's reactions, 70-year-old Lily said:

Yeah, probably. It was because the teaching in those days was that girls didn't get into those situations, you know, that kind of thing. I may have felt that somehow I put myself in that situation although I really knew I didn't on purpose or anything like that And we were not taught to do that unless it was serious. We were more taught to keep care of ourselves, you know.

Peter's fear of talking about his internment in a Japanese work camp was related to the feeling that he was the enemy: "That fear, the constant fear that you are constantly the enemy."

Like feelings of shame, feelings of fear were an impediment to disclosure for both the women and men in this study. However, as with shame, there were gendered nuances. Once again, women's fear regarding disclosure was typically grounded in their fear of being blamed, whereas men's fear was entrenched in their perception that they would be viewed as inferior.

Negative Reactions to Initial Disclosures

Despite the barriers that shame and fear posed to disclosure, some of the participants who were sexually and physically abused indicated that they still attempted to disclose their experiences to their parents or other significant adults in their life. Most of them, however, were rebuked or disbelieved. For example, Ruth, a 63-year-old woman, said that she told her mother about being molested by her father's friend when she was 5 years old:

And when I ran to get my mother and tell her what he did, she said "[J:Name], did you touch Ruth?" And he said, "No, you know I wouldn't do that." And I said, "You did so, you told me to take my overalls off." My mother didn't believe me and I was really fucking mad. That was my first experience.

Braveheart described trying to tell three different adults about the ongoing sexual abuse he was experiencing. Each attempt resulted in either a denial or dismissal: "I tried to tell my school principal at 10-years-old as best I could and was told I was 'making up stories'." Braveheart described finally disclosing his experiences of sexual abuse to his mother after he was beaten up by a group of boys at the age of 16:

Oh and my mother was like, "What happened to you?" and I started explaining. I just started blurting out everything, about the sexual abuse and the racetrack. I just ... I said, "I can't take it anymore." I just couldn't take the bullying and the name calling, and I just, everything just came up.

When asked how his mother reacted, Braveheart said: “Very strangely... she said ‘now things can’t happen to you like that,’ and we never talked about it again, ever.” He went on to explain how he tried to tell his Minister a few years later, but was simply told that the “military would do me good.” As a result, Braveheart said, “I just ... as always, stuffed it.”

That feelings of shame can be imposed by other people’s negative reactions to abuse was illustrated by Quasimodo. He described how, at the age of six, he was playing at the back of a store when a man forced him to perform fellatio:

I started then panicked. I panicked and left. I told dad when I came in, and I remember I was saying ... how the hell did I say it again? “He had a big hotdog,” like my point of view. I remember telling that to dad and dad said, “I don’t want you ever to say anything about that again, not even to your mother.”

Quasimodo continued:

I think that’s the biggest one that stayed with me for the rest of my life was that instead of saying, you know, “Show me where that son-of-a-bitch is. I’ll beat the shit out of him” or something like that, you know, but he, he cleared it completely away and just forgot it. But I never forgot it, it stayed in my mind.

When asked what motivated him not to talk to anyone else about the incident with the old man behind the store or other sexual abuse he experienced as an adolescent, Quasimodo was blunt: “Shame.”

That a positive reaction to a child’s disclosure of trauma can play a critical role in mitigating the harmful aftereffects of that trauma (such as shame) is demonstrated quite poignantly by Nadia’s discussion of finally telling her mother and the doctor about being sexually abused as a child:

Query: Did those feelings of fear also go when you told your mom?

Nadia: Yeah, when I spoke with the doctor [with her mother], everything gone.

Query: So every bad feeling you had was just...

Nadia: Disappeared. Just like I was purified.

Participants such as Ruth, Braveheart and Quasimodo, among others, were able to overcome their fear and tell an adult what was happening to them. However, the subsequent negative reaction to their disclosure served to exacerbate or bring on feelings of shame and fear.

Seemed “Normal”

Some participants discussed how their traumatic experiences seemed “normal” and that other people were experiencing the same thing. This perceived “normalcy” had an effect on their willingness to talk about their trauma-related experiences.

This feeling of “normalcy” had very different impacts depending on the type of trauma participants experienced. For example, many of the participants who experienced sexual or physical abuse were able to rationalize their treatment and subsequent nondisclosure by believing that it was normal for adults to abuse children. In other words, they believed that other children were dealing with the same experiences. It was also normal for people to not talk about “such things.” Daisy, a 61-year-old woman who was physically abused as a child, talked about never telling anyone about the abuse she experienced at home because it seemed normal: “I didn’t realize it wasn’t normal until I’d grown up and left home and that.” Feelings around abuse being normal were also evident in the following exchange with Tulip, a 65-year-old woman who was sexually abused as a child:

Query: Did you tell anyone or talk to anybody about it [the sexual abuse]. Friend, sister?

Tulip: Oh nothing, it was all normal.

Query: And you never thought about ever telling anybody?

Tulip: No! I mean who, who you gonna tell?

Query: So what motivated you not to? Can you remember?

Tulip: I never really thought about whether I should or shouldn't. It was just the way we lived. I mean, uhh... I mean...it was status quo.

Indigo, a 62-year-old man who was physically abused and neglected as a child, echoed the comments made by Daisy and Tulip:

Well, you didn't talk about it, first of all, those things in those days ... The rest of the family didn't talk about it so hey, maybe that's the way it is. So maybe I should be grateful for somebody looking after me for 2 years while my parents were away. So you try to rationalize it.

The notion of "normalcy" played out quite differently for participants such as Noah, Penny, and Michael who experienced war-related trauma, as well as for Gung Ho and Lucky, who experienced multiple deaths of significant others as a child (Gung Ho) and a life threatening illness (Lucky). For them, a sense of 'normalcy' could be defined as the perception that there was community acknowledgement and "others were going through the same thing." This sense of normalcy made it easier for them to talk about their traumas. For example, Penny, a 74-year-old woman who lived through the World War II Blitz in Britain,¹³ stated that,

It was normal I think. To me it was normal to get out of bed at night because somebody was dropping bombs, you know. I think by the time I'd gotten a little older I had begun to realize, you know, like you get up and listen to the bombs dropping and then I would be a little nervous about it because I was old enough then to understand.

¹³ During World War II, Germany began daily bombing raids on Britain, particularly at night, which lasted for 7 months.

Michael, who also lived through the Blitz, regarded it as a type of adventure: “I think about the fun in the tube. I can remember taking our blankets and pillows and walking to [N: name] station just a few blocks from home. It was fun.”

Similarly, Noah, an 83-year-old Jewish man who survived two years in a Nazi work camp during World War II, stated that:

We talked to each other, and we had friends. New friends, new friends. But they were all survivors, they were all - we avoided to talk about this, and we didn't see in each other that we are something less than anyone. But in this place, everybody has a story.

Interestingly, Peter, who, like Noah, was interned in a work camp during the Second World War, had a far different experience, an experience that was, and still is, plagued by feelings of shame and guilt. Indeed, the comparison between Peter and Noah is a significant one. Shame and guilt defined (and continues to define) Peter's experience of his internment in a Japanese concentration camp (and his subsequent and current problems), including his inability to talk about his trauma-related experiences. However, Noah, who also lost family and was interned in a camp, did not discuss having those feelings and had no apparent problems throughout his life in relation to it. The absence of shame or guilt seemed to play a pivotal role in Noah's subsequent well-being. These differences suggest that the ability to acknowledge trauma, be it through a sense of community or individual disclosure reduces feelings of shame. For example, Noah described an experience he had meeting a Jewish woman at a train station the day after he was released from the concentration camp:

I said, “I'm Jewish, not Georgian.” She said, “I am too.” And then, we were talking already a little bit. You feel a little bit different, and we became friends. I became friends with her husband, she was a medical doctor. I became friends

three - or two, doctors, women, and two teachers, women, and their husbands, and you know, when you are in a camp, and you have this kind of ...they treated you equal. I told the story and everything.

This sense of collectivity, or the knowledge that others had gone through the same thing, made it easier for Noah to talk about his traumatic experiences.

The sense of collectivity or 'normalcy' was also discussed by participants who experienced non-interpersonal traumas such as multiple deaths of loved ones, life-threatening illnesses as a child, and divorce. For example, Gung Ho, a 66-year-old man who experienced a string of deaths of close friends and relatives in his youth, said:

.... the deaths were beyond my control, and I think psychologically, I had trouble with them for a month or two, but gradually - I still have trouble sometimes, but gradually, I can sort of rationalize that by saying I couldn't do anything about it anyway.

For those who felt a sense of collectivity, or whose trauma did not lead to feelings of shame, there was an opportunity and willingness to talk openly about their trauma. For example, when Penny was asked if she felt that she could talk openly about her experiences related to living during the blitz in Britain, she responded,

Oh yes. You saw people helping people and stuff like that. Everybody was going through the same things, everybody. I mean, we closed ranks, which I think people do when they're under a certain stress, where maybe they wouldn't get along very well in other circumstances. Well, you know, when they have a common enemy, they're not each other's enemy.

Similarly, Gung Ho described the strong social support he had following the deaths of close friends and family: "I talked constantly to my mother, and I had a favourite uncle [...] and he would come over and talk a fair amount, and I'd go over to his place, and he became sort of a, you know, special uncle."

Likewise, Lucky was asked whether he talked freely about the issues he faced with his life-threatening illness as a child, he responded. “Yeah, I think I always did. I think I always did, and I’ve got a lot of that from my mother and my uncle.”

Thus, simply being able to talk with other people about their traumatic experiences mitigated some of the negative feelings associated with interpersonal traumas, particularly shame and fear. As a result of this ability to talk about their traumatic past, these participants were far better off psychologically than participants who were unable to disclose or openly talk about their experiences.

In sum, the participants in this study indicated that disclosing their trauma during childhood depended to a large extent on whether they felt shame, fear or that they could talk freely about their trauma due to their perception that it was “normal.” For some participants, however, the significant adults in their life did not believe their disclosure, which had a profound effect on them.

Adulthood: Disclosure and Help-Seeking

Disclosure

Problems with disclosure of previous traumatic experiences can persist into adulthood. In this regard, many of the women and men in this study indicated that their attempts at disclosure during adulthood were also unsuccessful. This was primarily due to persistent feelings of shame and fear, and their expectation that their experiences would be minimized, an expectation based on people’s reactions to their childhood disclosures. Not surprisingly, participants who felt they could talk more freely about their trauma as children (i.e., Gung Ho, Lucky, Noah and Penny) indicated that they had no issues talking about their past as adults. Moreover, they did not feel the need to seek

help for any trauma-related difficulties. Given this, the focus in the following sections are on those participants who experienced primarily sexual and physical abuse, with the exception of Peter, who was interned in a Japanese concentration camp during World War II.

Shame and Fear. Not surprisingly, feelings of shame and fear continued to inhibit many participants' willingness as adults to talk about their childhood trauma. For example, Braveheart discussed how fear played a large role in his professional life and subsequently led to going to prison for fraud:

I was constantly afraid of people talking about what had happened to me as a young boy. There were people in the investment business who knew me as a boy, and I was afraid if they knew, I would be victimized again (...) I became an imposter. I became a total imposter in my lifetime. Well you try to be somebody else. You're not yourself because you're afraid of being exposed and being victimized again.

Interestingly, Braveheart went on to explain why he stole money from his clients:

It was really just about getting people's trust and then abusing them through their money, all in a misguided effort to get the power back that had been taken from "the little boy inside."

Daisy did not talk about her trauma-related problems due to her fear of confrontation:

I'd basically hide [my problems] from them [her family]. I wouldn't talk about them, and they would just get bigger and bigger and bigger. Sometimes only in my mind, sometimes in my mind they would grow, and if I could've talked about them, then things might've been different, but I just couldn't bring myself to. But I didn't want a confrontation with somebody. I wanted things to go smooth.

For Tulip, the shame of staying with a husband who battered her kept her from talking about her abuse:

Well what woman, well I won't say that, but a lot of women don't want to admit that they married a man who abuses them because they feel it's a reflection on themselves. Oh ya, sure I did [feel that way], damn right I did. Boy I was really down on myself.

In summary, although the basis of participants' adult feelings of fear and shame were definitively different from those underlying their childhood feelings of shame and fear, these feelings were nonetheless powerful factors in many participants' inability to talk about their traumatic past as adults. Moreover, these feelings of shame and fear were expressed by both women and men.

Expectation that experiences would be minimized. Many of the participants indicated that their attempts at disclosure during childhood affected their willingness to talk about their traumatic experiences in adulthood. Specifically, they expected that their experience would be minimized or, due to a previous negative reaction, anticipated the same rejection as an adult. Peter, for example, discussed how his attempts to talk about his internment in a concentration camp were dismissed:

The worst part is that, when I came to Holland, most people said, "Oh, that's not so bad because you had no winter, and you were not the Jew", you know. And then after the war, the lack of understanding ... and I had one counselor who counseled Jewish kids in Holland. He said, "Oh, you don't know, you didn't suffer, OK?"

Susan described a similar minimization of her childhood experiences:

So, if I was telling someone they'd basically, "Well, [Susan], you had perfectly good parents. There was nothing wrong with your childhood." So after a few things of that it's like, "ok sorry, sorry to bother you."

Moreover, as adults, participants who experienced negative reactions to their childhood disclosure, such as denial or minimization, experienced more psychological

problems, were less likely to have disclosed, and were less likely to have sought help for their problems. In this regard, all six of the participants who had negative disclosure experiences during childhood had PTSD, and five of the six reported being depressed. This is in sharp contrast to the five participants who said they could talk freely about their trauma, where only one person reported any mental health issues – possible bipolar disorder.

Many participants indicated that negative reactions to their childhood disclosure of their traumatic experiences profoundly affected their willingness to talk about or disclose their trauma in adulthood. For example, Susan explained why, as an adult, she did not tell anyone about being raped as a child: “I think I’ve tried to tell various people but it was like, one of my things was, because of my experience as a young child, no one believes me.”

Susan explained how she was affected by being neglected and not having her rape discussed or her feelings stemming from the rape addressed:

So there’s D:[name]. I don’t know if you know his stuff but he basically says as a mature adult - as a mature anybody, child, adult, teenager - we should in this world feel lovable, valuable, capable and equal. And I felt none of those.

Quasimodo expressed similar feelings when he described his father’s dismissal of his disclosure of sexual abuse:

And the funny part about it is you always want to prove to them [dad] ... you need their love so much, it’s a hunger that you need to have, you know? If dad only would have told me once on his life “I love you,” I mean that would have cleaned up the slate. You know?

When asked if she told anyone else besides her mother about being sexually abused by her father’s friend, Ruth replied:

No, because I figured, well my dad wouldn't have believed me. He brought the guy into the house in the first place. He was his friend. If my mother didn't believe me, who the hell else was going to believe me? I never told anybody, and you know what? Until this day I have never told anybody about that experience. Why not? I think mostly because my mother didn't believe me. That made a big impact on me and then, I just got angry. I just got angry. I just never told anybody. I just stayed mad inside.

In many instances, the reaction to the disclosure of trauma or problems associated with the trauma by family or other significant people acted as a form of secondary traumatization. That is, positive or negative reactions either attenuated or exacerbated, respectively, the factors associated with nondisclosure. As such, almost all of the participants who were unable to talk about their trauma, either due to shame, fear or a negative reaction to their initial disclosure, continued to experience trauma-related problems into adulthood.

Help-Seeking in Adulthood

While disclosure to family or friends was the primary way participants talked about their trauma, if at all, they also sought help from professionals, particularly general practitioners, psychologists or psychiatrists. Not surprisingly, none of the participants indicated seeking help from professionals during their childhood. Moreover, a number of the participants indicated that they had sought help from their general practitioner due to problems such as panic attacks (e.g., Ruth, Braveheart), depression (e.g., Quasimodo, Tulip), and many continue to use their general practitioner as their sole source of professional support. Given the significant psychological problems that participants indicated they were experiencing, the lack of help-seeking was surprising. More alarming, perhaps, is that many participants described opportunities where

therapy/professional help could have been accessed, but these opportunities were often missed because the therapy was not focused on their traumatic past.

Help-seeking/therapy not focused on trauma. Despite the many psychological problems associated with earlier traumatic experiences (see Table 2), eight of the 16 participants indicated that their first experience with professional help occurred when they were in marriage counselling, which typically occurred in their late 30s or early 40s. Participants described varying experiences with the effectiveness of this counselling, particularly given that its focus was typically not on traumatic experiences. Two other participants (Ruth and Tulip) said that they sought help for their problems only when their life circumstances forced them to. Ruth started to see a psychologist when she started having panic attacks after the death of her sister. Similarly, Tulip sought help from a psychologist in her early 40s when she also started experiencing “unexplained” panic attacks. Tulip ended up at a women’s shelter when neighbours confronted her about the abuse she was experiencing at the hands of her spouse and she agreed to go. As adults, 10 of the 16 participants had sought help from a psychologist or psychiatrist, but none of them reported that the counselling they received actually focused on their traumatic past. For example, Susan described her experience seeing a psychologist when she was in her late 30s: “I went to see a psychologist for four years who was, he was useless.” When prompted to explain why she felt he was useless, Susan said:

First of all, no one, until I started getting treated, no one understood that I was dealing with posttraumatic stress. And dealing with posttraumatic stress is very different from dealing with day-to-day stuff. But basically, I mean, what I needed were not tranquilizers. What I needed was what someone is doing right now [providing trauma-focused therapy].

Susan went on to describe how she was unable to convince her family doctor that she was critically in need of help:

Anyway, so I said, "Please send me to a psychiatrist" and he said, "Susan, I can't." Because in those days it meant having to go to T:[city] from P:[city]. He said, "I can't refer you to a psychiatrist. You're not sick enough." Ok, well what am I supposed to do? In those days, you didn't really go to a psychiatrist unless you were a schizophrenic or something.

Quasimodo described his first experience of help-seeking through marriage counselling:

It was just for the marriage, and that was when I started seeing a psychologist. And, I saw him for, oh god knows for how many years, and in those days Valium was the only stuff they gave you and nothing else. So he gave me Valium to relax, to meditate. Yeah, talked about it and all this, and talked about [J:wife], talked about my youth, talked about dad and all this. Not sexual abuse. Sexual abuse came out a long, long time after.

That childhood experiences of sexual abuse were not even considered as a possible causal factor in participants' psychological difficulties is highlighted profoundly by

Braveheart's discussion of what he called his "years of crisis," which began in his late 40s and endured into his 50s:

During these years, I had been suffering from a lot of stress and insomnia because of travel between M:[city] and O:[city], plus financial problems with the banks and business associates. Then, one night in 1994, I found myself standing beside my wife's bed as she slept. I had a heavy rock doorstopper in my hand. I didn't remember getting the doorstopper. It was as though I had just awoken from a trance. I replaced the doorstopper, left the bedroom, went to our spare room and then left very early in the morning. I knew that I had to tell my wife what had happened [that he almost bludgeoned her with a rock], and when I did so, she asked me to leave. It was at this point in my life where I finally went out and sought help. I needed help. I was out of control. And so I went to the R:[mental

health hospital]. At the hospital, we discussed my life history, including the sexual abuse I had experienced as a young boy and the lack of a father while I was growing up. I had come to my own conclusion that I had been fighting my own war with what was going on with the "little boy" inside me, but after a number of assessments, they only said that I came from a dysfunctional family and had an alcohol problem.

Similarly, when Cinderella discussed seeking help related to her marriage difficulties, she indicated that nothing about her sexual abuse was discussed:

No, not that I remember about the sexual abuse. Maybe I did talk about the emotional abuse by my mother, perhaps. But I think I just went a few times. It was not a long therapy or even a therapy, a few sessions probably, because he was not paying. So I had to stop because he was not being paid. It was just a few times.

Ruth also described how, in her 30s, she was "forced" to seek help:

I tried to commit suicide and I was forced in to opening up my mouth ... I went to a place called Freedom from Fear. My doctor put me onto it at the time down in H:[city]. It was a group of people that like me had panic attacks, obsessive-compulsive disorders, manic depression. And they had 2 psychiatrists on a panel and they were just a couple of idiots. They were husband and wife team and they didn't address the issues at hand. Even the one guy in the group says, "You know, you two are sitting there laughing and what part of this do you think is funny?" And I said, "Bravo!" because they didn't address the issues that were bothering us.

Peter described how, after being thrown out of his church as a pastor for espousing controversial views, he sought psychiatric help from three different psychiatrists. None of them ever asked him about his previous experiences: "No, never, never. You may well know that you are the first one that talked to me about it." When further prompted if it was because he did not want to talk about it or because they did not ask, Peter explained:

I do want to. I do want to talk about it. But the difficulty is that they feel that I know enough, if I know much more. The difficulty is that, because of my ... they often give guidance, or whatever you want to call, that they feel, you know, that I can handle it better. But people don't know how much, when I am alone, how lonely I am at times, and how unhappy it can be, you know. I am an unhappy person by, from character, but the difficulty is that no one dared to move into that world. And if it's true [that he can handle it better], I don't know what to do about it.

That therapy that focuses on their traumatic past can in fact dissipate the persistent feelings of shame experienced by these trauma survivors was illustrated by Tulip:

Well anyway, this horrible, horrible sense of shame, that as I say, after I got out of the shelter I've never had them since. There was a whole lot of things that came out [as a result of being in the women's shelter] to do with sexual junk. I felt relief. It just felt right, I was glad.

Tulip also described how she started to recover memories of abuse during her stay in the women's shelter:

Whole pile of them, some of the things I've told you, but other things too, kept coming out. And I asked the counsellor, I said, "Why is this happening?" And she said, "Because you feel, for the first time in your life, safe. For it doesn't matter who you are, what you are, what you say, what you do, nobody is going to hit you, condemn you, ridicule, criticize, or laugh."

For most of the participants, then, there were many missed opportunities to help them with their trauma-related difficulties. These missed treatment opportunities stemmed from healthcare professionals' lack of knowledge and/or receptivity and participants' general unwillingness to openly discuss their traumatic past. Moreover, many of the participants described not just one, but repeated instances of contact with

mental health professionals that were ultimately unsuccessful. However, some participants indicated that the help they needed (i.e., that focused on their traumatic past) did come, but not until well into their 40s and 50s. For example, after a second suicide attempt when she was in her early 40s, Ruth finally met a psychiatrist who wanted to discuss her past and its impact:

[I was] in my 40s. And I was severely, well, I was severely depressed. I was on medication and he was the new doctor when we moved up to [K: name of city]. So, he says, "Okay, this happens because people bottle stuff up. I don't care if it was yesterday. I don't care if it was 10 years ago." He said, "There's something bothering you and this is your body's way of saying you need to get it out of you." And I say, "Well, I don't know." And he says, "Yeah, you do know" and he says, "It's gonna take a while obviously to get it out of you." But I say, "Well, I won't tell you everything, I tell you that right now."

Indigo described being a severe alcoholic for 25 years, which resulted in several hospitalizations due to black outs and concussions. Despite being in contact with the medical profession for many years, he saw a psychiatrist for the first time at the age of 52, which led him to enrolling in Alcoholics Anonymous. When asked about the usefulness of that intervention, Indigo said:

Well, within the context that I was in, working with the psychiatrist in AA, it was normal [a history of child abuse]. Almost everybody I talked to had a very similar experience so you know we're not alone anymore. And many of them were still struggling with it and how to deal with it and seeing therapists, psychiatrists, medications and all these kinds.

Finally, Daisy described how she finally talked to her family doctor about being physically abused by her mother:

It was like a weight being lifted off my shoulders. It was good. When he said, "You know, you're not at fault," and I started thinking about that. He was right. I

was a child when all this was happening.

Taken together, for many participants, help-seeking was not successful because it did not focus on their traumatic past. Moreover, for some participants, the help that did come may have been too late. Unfortunately, given the high rates of mental health problems experienced by the current participants, their help-seeking, even after many years, was ineffective at best.

Disclosure and Help-seeking in Older Adulthood

Disclosure

One of the most profound findings of the current study was that many of the participants were still living with the aftereffects of their trauma. As Braveheart put it:

I have carried this inside myself throughout my life, to the present day life I live. I experience flashbacks about traumatic events that relate to my childhood and periods of my past. This regression brings on deep depression, and I isolate myself from the outside world. I can't function some days because of the feelings of anxiety and depression. I feel unbalanced and have mood swings from depression to anger. At this time, I don't want to be around people. This happens at least one to two times a month and covers spans of one to three days and nights, with very little sleep, nightmares, guilt and very low self-esteem.

This inability to put the past behind them or to successfully cope with it in the present was also mentioned by Peter when he said, "That is the difficulty, if I may say to you, the difficulty is, I don't know how you can unburden yourself from the past."

Despite their disclosure and help-seeking experiences in early and mid-life, the participants' willingness to talk about their traumatic past or their psychological problems were profoundly affected by aging. This effect of aging was evident in two distinct ways: 1) the process of reminiscing about their life, a process associated with aging, seemed to

exacerbate participants' mental health problems; and 2) aging seemed to make participants feel more confident and open, which in turn increased their willingness to talk about their traumatic past. The latter point may explain why I was the first person that three participants had ever talked to about their experiences and psychological problems. That aging itself rekindled some of the feelings of the past was expressed by most of the participants. For example, Nadia discussed how she keeps thinking about her molestation experiences as a young girl: "I pray all the time. At night, sometimes I think about it, I don't fall asleep. I pray to God to switch my thoughts, to take the heavy burden out of me." Interestingly, although Nadia indicated that the shame and guilt she felt from being molested as a child disappeared when she learned that her virginity was intact, she expressed feelings of depression and anxiety. In addition, she revealed that I was the only person that she had disclosed to since she had told her mother 60 years prior to the interview. Nadia also discussed how her current experience of financial stress was affecting her psychological state: "I have things financially depress me and that's why. My house won't sell. I need to carry the house. I have no pension, you know. I have only the old age pension." Likewise, Quasimodo said: "As I get older, those memories [about abuse] come back stronger." When asked if things had worsened since his retirement, Quasimodo said: "Yeah, oh yeah, much worse. I have more time on my hands and all this and uh, I find I'm more prone to suicide more than I was ever before."

Peter, having recently written a book about his experiences in the work camps in Indonesia during World War II, said:

I'm very anxious - I have to tell you that I have had a lot of surgery, over eighteen surgeries, and so I have to face another cut to get artificial knees and hips - but it's because I dream a lot, and it often comes back [his experiences in the work

camp]. After I finished the book in December, I feel a bit more liberated, and I have some people who were upset about it. But, you know, everything comes back. It's always on the surface of my mind.

Peter added: "I don't know, it is for me still difficult when I get depressed because of the trauma about the past, and I do - just after Christmas, I had a terrible time ... Well, you know, I wished I was dead."

Particularly important here is that many participants indicated that they continue to think about events that, in some cases, happened over 60 years ago and are still profoundly affected by them. Despite these lingering effects, many participants indicated that they were still reticent to discuss their traumatic past with the people in their lives. This reluctance to discuss their past was, in some cases, associated with persistent feelings of fear and shame. However, having experienced a negative reaction to their disclosure as a child or as a younger adult seemed to be the most important factor in their unwillingness to disclose.

That feelings of shame and fear became deeply ingrained in the participants' understanding of their traumatic experiences and persisted into their later years was illustrated by a number of participants. For example, Quasimodo explained how shame kept him from talking to anyone about the abuse now. He explained, "you bury that very deeply. It's an automatic thing. You put a mask on or whatever you want to survive it. So I had it buried so deep that I didn't even think about it."

Peter also articulated that fear continued to affect his willingness to talk about his trauma and explained that, originally, this fear held him back from publishing his book about his traumatic experiences:

You're scared because you're just like, you're naked, you say how you feel, you

know. Some people found it frightening that I thought everything that I thought. It was written as a fourteen year old. As I said fearful, you know, maybe the best word for it.

However, the very fact that these participants agreed to be interviewed is evidence that their willingness to talk about their traumatic past has increased with age.

Help-Seeking in Older Adulthood

Given that many participants were still not disclosing their traumatic past in their later years, it is not surprising that their help-seeking was also limited. Many participants indicated that they did not seek help from professionals in their later years due to: 1) being disillusioned with professionals because they feel that healthcare professionals do not believe them or understand them; and 2) ongoing distrust that was originally instilled by their trauma.

Although most participants described being at a point in their lives where they no longer felt the need to stay quiet about their past experiences, only Braveheart, Gung Ho, Indigo and Susan were receiving professional therapy at the time of the interview. This is striking in light of the severe psychological issues many participants were struggling with, issues that included depression, panic attacks, suicidal thoughts and PTSD (see Table 2). It would seem, then, that participants' disclosure and help-seeking experiences in childhood and earlier adulthood had enduring effects.

Being disillusioned with health professionals. Many participants alluded to being disillusioned with professional caregivers because of their unsatisfactory experiences with them both in the past and the present. For example, Tulip discussed how she did not seek help because she felt that professionals did not understand what she was going through. When I asked Tulip whether she now talks to any professionals about

her current experiences of depression, suicidal ideation and anxiety, she responded:

“No, you’re the first person.” When I asked her why I was the first person, she explained: “Because I don’t feel like they understand, that’s why. How I feel right now, today, in my life I do not want to. I don’t see any point of going on [about the past].”

Braveheart described reliving the feelings of fear and powerlessness that he had originally experienced at the time of his trauma when, at the age of 55, he sought psychiatric help. At this visit, Braveheart said:

I discussed the sexual abuse I experienced as a young boy, the lack of a father growing up during war time. After a number of assessments, they said that I came from a dysfunctional family and had an alcohol problem. About a year later, I was back at the [hospital], and this time I was suicidal and had a knife on my person. The psychiatrist I saw previously passed me on to a second psychiatrist. In seeing the doctors at the R:[hospital], it rekindled the feelings of being victimized again, and I was experiencing many sleep disorders associated with PTSD.

According to Braveheart, not being listened to rekindled his earlier feelings of powerlessness and fear associated with previous traumatic experiences.

That help-seeking experiences can rekindle feelings from past traumatic experiences was also indicated by Susan when she described going to her family doctor for her ongoing physical problems:

[The stress from my previous trauma] has led to a whole bunch of physical problems. Umm ... plus it was discovered in June that the thing that I’ve been intolerant of all my life to is fruit and soy products. And when I finally went to see a naturopathic doctor 12 ... 14 years ago [when she was 60 years old], and by then my stomach aches were becoming a doubled over experience and I was sent for all these damn tests and there was nothing. Everything’s fine. My stomach

aches are in my imagination. That was another, another kind of thing that was really stressing, not being believed again.

Taken together, these participants' narratives on seeking help in older adulthood point to participants' general feeling of disillusionment with the ability of healthcare professional to address their ongoing trauma-related problems.

Ongoing distrust. Some participants also described an ongoing mistrust that stemmed from their earlier trauma experiences. This ongoing mistrust is most poignantly demonstrated by Ruth and Tulip. For example, Ruth explained how her feelings of mistrust led her to initially withhold information from her general practitioner:

It always comes down to a trust issue. I had to scope it out first, you know. And then he got me talking one day and I told him that I was abused and the different ways I was abused. And this ever vigilance. I was an insomniac. I suffered from lethargy the doctor called it when I was 8 years old and that is depression. They couldn't figure out what was the matter with me. I was just a worn out little kid because I was so vigilant all the time. How can a person keep going like that? But like I said, I got married and I was happy and you stick it all in the back of your mind and you try to forget about it. But then it rears its ugly head.

Similarly, Tulip explained: "I've learned, umm ... see it used to be that everything else, because of the abuse ok, I was brought up not trusting anyone." This lack of trust is particularly alarming given the pressing help that Tulip, like many of the participants, needed in order to have her mental health issues addressed:

Tulip: I can't. Yesterday I was suicidal, ok? You think I can tell my doctor that?

Query: Why? Because you're afraid of what he's going to think of you?

Tulip: No. I'm afraid he's going to order anti-depressants for me and I don't want them. I will not take them. I have tried that route. Don't want pills.

I hate pills. I mean I take supplements you know you see me being whatever 'cause I have rheumatoid arthritis and I take an anti-cancer drug but no, I don't want them [anti-depressants].

When I asked Tulip why she did not want to go on anti-depressants, she said when she tried them in the past they “didn't do anything.” I also asked her if her doctor provided her with any alternatives to anti-depressants or offered to refer her to counselling. Tulip responded:

Oh yeah, he has asked me would I like to go see a shrink. Of course O.H.I.P doesn't pay for psychologists. I mean they pay for a shrink. The thing is I don't need a shrink. I've done the trip, I have figured myself out. I know who I am. I know why I am. All I wanna do is move on. I just want someone to tell me what to do next and I want it to be a person I believe. Now I mean, that's asking a lot ... and probably I'm just trying to cop out of life or something. Don't ask me. I don't know. I really don't know.

Of note, all of the participants, including those who were able to talk freely about their traumas as children (i.e., Noah, Penny, Michael, Gung Ho and Lucky), indicated that the primary focus of their current engagement with health professionals was related to their physical health. In light of the long history of failed attempts at disclosure and help-seeking described by most of the participants, it is not surprising that these feelings of disillusionment and mistrust would persist into their senior years. What is remarkable is that some still tried, after so many disappointments, to get their story out and to get help for their trauma-related problems.

Summary of Grounded Theory Analysis

At first blush it may appear that the fundamental difference between people who did versus did not disclose their traumatic experiences lies in the type of trauma they experienced as children. Nine of the 16 participants indicated that they had talked about

or disclosed their traumatic experiences during childhood. Braveheart, Nadia, Quasimodo, Ruth, Susan and Tulip had all experienced sexual abuse and/or physical abuse. The remaining three experienced warfare (Penny), multiple family deaths (Gung Ho) and internment in a concentration camp (Peter). However, the common thread between the type of trauma experienced and psychological and physical well-being appears to be participants' persistent inability to talk about their traumatic past and the fundamental failure of their families, friends and health professionals to acknowledge or address their trauma-related problems. This lack of acknowledgement, in turn, reinforced their original feelings regarding their trauma, feelings that included shame, fear and a general sense of being unworthy of care.

During childhood, feelings of shame and fear impeded many participants willingness to talk about their experiences of trauma. For those that were able to disclose their trauma, the reaction to that disclosure by family or other significant people had a profound effect on whether their feelings of shame and fear were exacerbated or dissipated altogether. A negative reaction, such as one where the participant was rebuked or disbelieved, reinforced feelings of shame and fear. This reinforcement resulted in participants' living with an inability to disclose or seek help throughout their lifetime and this, in turn, led to psychological problems such as PTSD and ongoing physical ailments (see Figure 2 which illustrates the cycle of shame/fear and disclosure).

In adulthood, reasons for nondisclosure included persistent feelings of shame and fear, and the enduring effects of a negative disclosure experience during childhood. As a result, many participants had an expectation that their trauma-related experiences would be minimized. For those that did receive professional help such as counselling, they

indicated that the therapy was ineffectual because it was not focused on their trauma-related difficulties. In fact, in most cases, the focus of the therapy was on marriage difficulties.

Figure 2. *The Cycle of Shame/Fear and Disclosure and its Impact on Older Survivors' Well-Being*

Finally, the cycle of non-disclosure persisted well into the participants' senior years. Feelings of shame and fear persisted and affected their willingness to talk about their childhood traumatic experiences with family and friends. In addition, efforts to seek help were impeded by a general disillusionment with health professionals based on their past and present experience as well as ongoing distrust that stemmed from earlier abuse experiences.

Taken together, the grounded theory analysis revealed that negative disclosure experiences (i.e., when the participants' trauma and its effects were not acknowledged or believed) served to exacerbate feelings of shame and fear that persisted throughout the participants' lives. That is, participants who felt that they could acknowledge their past (either because it was okay to talk about it or because their disclosure was believed) were less likely to need therapy and faring well psychologically in their later years. However, for participants who had their disclosures suppressed, rebuked or disbelieved, the feelings associated with those reactions became deeply ingrained in their understanding of their trauma as well as their "perceived" role in their traumatic experiences (i.e., feeling somehow responsible for the traumatic experience or as "damaged goods"). As a consequence, they continued to deal with the psychological and physical effects of their earlier trauma well into their later years.

Discourse Analysis

Because the discourse analysis was conducted to identify discourses that were likely to impede participants' disclosure of their traumatic experiences, the analysis was limited to those who had difficulty with disclosure and/or help seeking. As such, while all transcripts were examined, this analysis focused mainly on women who had experienced sexual or physical abuse as children and men who experienced sexual or physical abuse or, in Peter's case, internment in a work camp during World War II. The discourse analysis revealed a number of gender- and age- related discourses in participants' discussions during the interviews, discourses that had important implications for how participants understood their traumatic experiences and the likelihood that they would disclose these experiences to others.

Gender-Related Discourses Relevant to Trauma

As shown in Figure 3, gender-related discourses for the current sample included both discourses of femininity and discourses of masculinity.

Discourses of Femininity

The older women in this study drew on a number of discourses, discourses that were likely to detract from their willingness to disclose or seek help for their past experiences. Many of the women used language implying justifications such as *minimization of abuse* to understand their earlier traumatic experiences (see Figure 3, which lists the discourses). In addition, the women in the study who had been sexually abused tended to hold themselves *responsible* by viewing themselves as having instigated or provoked the abuse (e.g., by regarding themselves as being in the wrong place at the wrong time). Finally, these older women also articulated discourses that depicted women as *nice and passive*, a construction that seriously limited their ability to talk about their trauma or their trauma-related problems.¹⁴

Minimization of abuse. The *minimization of abuse discourse* encompasses a particular way of understanding and defining what constitutes sexual abuse. When talking about their sexual abuse experiences as children and youths, many of the women defined “sexual abuse” as being strictly limited to vaginal or anal intercourse. As a result, other acts, such as exposing genitalia, molestation or sexual harassment, were not viewed as “sexual abuse.” For example, Susan, who was repeatedly molested by a neighbour and eventually raped by him when she was 3-years-old, said,

¹⁴ None of these discourses of femininity were evident in the narratives of the men who took part in this study.

Figure 3. Gender-Related Discourses Relevant to Trauma

Well, a neighbour used to put me on his lap and stick his finger up my vagina. That happened a lot. But I wasn't actually sexually abused until he raped me in the barn when I was 3. ... So the actual rape thing only ever happened once.

Although Susan was sexually abused over a period of time, she only viewed sexual intercourse (the rape) as an act of sexual abuse. In addition, Susan's use of the word "only" also serves to minimize the abuse, as her use of the term suggests that sexual abuse is defined as ongoing, rather than a one-off event.

Similarly, explaining why she did not talk about her uncle's attempt to rape her when she was 13-years-old, Lily said: "Now if he had actually sexually assaulted me or done any harm, well there would have been other repercussions." In this instance, Lily minimized her uncle's sexually abusive behaviour by restricting her conceptualization of sexual abuse or assault to intercourse, viewing *attempts* at rape as less severe and not in need of redress. Tulip, who as a youth was sexually abused by her father and stepfather and later battered by her partner, also minimized her father's actions by adhering to an inappropriately restricted definition of sexual abuse:

There's something that, if it comes to sexual abuse that would say involve intercourse, I would most definitely have to say that that never happened. ... And there's just no way he was a sexual abuser [her father]. I mean children just love that man so much, ... Uh, sexual abuse ... but he did other things. He did, um, oh -things like, uh, flicking my nipples, you know, pinching them. He would walk into the living room and expose his genitals to me. That sort of thing. But no, I wouldn't say he sexually abused me.

Like Lily and Susan, then, Tulip defined sexual abuse as involving intercourse and in so doing minimized her father's abusive behaviour.

The *minimization of abuse* discourse constrained women's perception that they were actually being abused and, not surprisingly, made them less likely to disclose the

abuse. The use of this discourse may also have detracted from these women's understanding of the negative impact of their experiences on their psychological well-being.

Responsibility to avoid abuse. Many of the women in the study also used language that implied that they were somehow responsible for trying to avoid circumstances that could put them at risk of being sexually abused or raped. In this regard, Lily said: "I had an inkling at that time from hearing mothers talking that people should sort of veer away from this fellow." Lily went on to explain:

... because the teaching in those days was that girls didn't get into those situations, you know, that kind of thing. I may have felt that somehow I put myself in that situation, although I really knew I didn't on purpose or anything like that. We were more taught to keep care of ourselves, you know. I could say, "Oh well, why didn't I tell someone and they could go get him." But, you know, they didn't do that in those days. They would tell the girls to stay away.

Cinderella also said she should not have put herself in compromising situations with the boys who sexually abused her on an on-going basis:

It's like I was in a state of shock. Each time it was happening and then I was kind of feeling forced and obliged and, you know, they were coming to take my hand and, you know, I could have said no. It's stupid. Today, I realize that it was stupid on my part to let that happen.

This excerpt clearly shows that Cinderella felt that she was responsible for avoiding the abuse and, when she did not, it was because of her own "stupidity." Cinderella added:

I was always reacting the same way I did at the age of 5 - unable to say anything. Plus we were not informed. The only thing my mother was telling me, "You don't let the boys touch you." That was the sentence, but she never said, you know, "Woah, wait a minute [the boys shouldn't be touching you]," you know. No.

These women focused their conceptualization of the abuse they experienced around their inability to prevent it from happening. In so doing they appear to have been drawing on a social discourse that holds women responsible for the sexual behaviour of men. Because other people may also hold this narrow and inappropriate view of responsibility, people to whom the women disclose may also use this discourse to dismiss these women's accounts of their experiences of abuse and, as a result, underestimate its importance.

Women as nice and passive. The narratives of many of the female participants also suggest that the feelings of anger that follow particular traumas are incongruent with cultural constructions of femininity that depict women as nice or passive. The fact that anger is a socially unacceptable way for women to react to trauma was illustrated by a number of participants. In addition, their attempts at keeping their anger "reigned in" affected their ability to talk about their trauma. For example, Susan said:

Well, as a child if I got mad and stamped my feet and stuff, I was told, "Oh now, now don't be angry dear, smile." And even my grandmother whom I adored was, you know, it was "smile dear and everything will be alright." I knew I was afraid. I knew that I was afraid all the time, but I didn't know I was angry. And I think that definitely from, just from what I've known and seen little boys are not allowed to be afraid, they're allowed to be angry. Little girls are allowed to be scared but no, not angry. When I first started in therapy there was all this stuff about anger and I kept saying, "I'm not angry; I'm just scared of everything." So basically all my anger got repressed.

When asked how she dealt with the anger that she felt from being physically and sexually abused as a child, Ruth responded by saying:

Actually, I didn't [deal with it]. I don't think I ever dealt with it. I think it was just there and I just kept a reign on it. I knew I had that anger inside of me so

you're ever vigilant about letting it come out. See my father was quick to beat us kids and I swore to God if I had children, anybody laid a hand on them, I'd kill them. But I never let that anger out – I just stuffed it down and never told anybody about it.

Cinderella also described how she used to turn her own anger inward so she could put forward a facade that she was healthy:

I was struggling to keep myself out of it [a psychiatric hospital], and struggling probably to look healthy, to act healthy, or to be healthy. I kind of had this little power inside of me. Maybe that's what saved me, I don't know. I'm still here. I know now that instead of turning the anger, which I was doing unconsciously, towards me, wanting to hurt me, or wanting to kill me, or whatever, now I get the anger toward others.

Thus, feelings of anger, which are incongruent with social constructions of being female, constrained many participants' willingness to discuss their trauma-related issues. Instead, they repressed their anger and tried to ignore the problems they experienced as a result of their earlier abuse.

In sum, cultural definitions and expectations associated with femininity and sexual abuse served in many ways to further silence those women who could not disclose their trauma experiences by minimizing what counts as abuse, by holding girls responsible for avoiding abuse, and by expecting girls and women to be nice and passive.

Discourses of Masculinity

As illustrated in Figure 3, men's ability to talk about their previous traumatic experiences were also constrained by common social discourses around being male. These discourses drew on definitions of men as *unemotional or inexpressive* and *self-reliant*. In addition, issues around *homophobia* and *heterosexism* also constrained some

older men from talking about their trauma, particularly those who had been sexually abused.

Unemotional, inexpressive. The male participants drew on the social discourse that depicts men as unemotional and inexpressive to explain their unwillingness to disclose or seek help. For example, Quasimodo, said:

... being male you don't tell. Because you're male, you can't admit that you made errors. You can't admit that you're hurt. You can't. You just don't. You don't cry. I can't cry. There's a vulnerability, especially crying for me, you know? And you try to protect that. There's a mask all the time. Mind you, you get knots in your stomach that you wouldn't believe but still, it's a good front.

Similarly, Michael commented:

I think men of my generation were taught that the male sex is stronger. Being soft and feminine was not really all that good. ... I held back. I don't remember specifically what I held back, but I remember thinking that you're taught to be strong and it's weak and womanly to be emotional.

These sentiments were echoed by Indigo, who experienced childhood physical abuse and neglect:

If your father tells you that's the way that it was and there's nothing that can be done, then you leave it and, you know, you put up with it because otherwise it was seen as feminine, you know, being female. It's only girls that cry.

Indigo continued:

So I basically felt frozen emotionally in time, which I stayed until I sobered up 10 years ago because I used the alcohol to do the same thing, as an anesthetic to dull the pain and to keep the memories suppressed and repressed. So I've learned these are the different defense mechanisms, so you deny it. ... So you try to rationalize it.

Interestingly, this discourse was also deemed problematic by men who indicated that they did not have trouble talking about their trauma as children. In this regard Noah, who survived the Holocaust and appeared to live a relatively healthy life, described a conversation he had with a friend regarding their Holocaust experiences:

He was crying, and crying, and I thought, he being Hungarian, why are you crying? You know, it doesn't help. This was my philosophy, crying doesn't help. [...] But, I talk about my life, but a man too, but I don't cry. I don't complain, you know, I'm fine.

Similarly, when asked if being a man has affected how he felt about his traumatic experiences or his willingness to talk about them, Gung Ho said:

Yes. ... That's because, whether it's true or not, there seems to be this perception in society that women can cry, and talk about it, and open up, and men are supposed to have a stiff upper lip and not talk about it, etc. And I think that causes men a lot of problems.

Finally, Lucky, who experienced a life-threatening illness as a child, responded to the same question by stating:

Well, part of it is the traditional image, where I come from - my father's a steelworker in M:[city] - and the image of a man was to be tough, show no weakness. If there's any tears, they must be tears of anger, frustration, not sentimentality or weakness. Recently when I had an MRI, the doctor said to me, you're never gonna run again. And of course I had some goals in mind to set the world record as a centenarian, or something, which has never been established. And I could feel the corners of my eyes tearing, and I said to him, "This isn't weakness, or pathos. It's anger and frustration. This is not gonna beat me."

Thus, men's unwillingness to appear emotional or to express any problems, such as any shame, fear or anxiety they were feeling due to their traumatic experiences, silenced them and potentially thwarted their efforts to seek help.

Men as self-reliant and strong. Social discourses that depict men as self-reliant and strong also detracted from older men's willingness to disclose or seek help for their trauma-related problems. For example, when asked why he did not talk about his abuse as a child, Indigo said, "You have to be tough and shut up." The unacceptability of men displaying weakness was also mentioned by Lucky:

Because despite the fact I've always been obsessed with achieving personal goals, I could never talk about it before. When I was much younger, I felt to talk about it would be to show weakness, and would suggest that I'm overcompensating, and I'd say to myself, "I'm not overcompensating, and I'm not going to open myself to those criticisms, so I'm not going to talk about it," and I wouldn't even mention it.

When discussing how being a man affected his willingness to talk about his experiences in an Indonesian work camp, Peter described the pain associated with the constraints of being male and unable to talk about his feelings:

Well, maybe it's a twist, being that the difficulty was that I - women were, are more emotional and [UNCLEAR] feelings. We offered in our tradition, in the Catholic tradition, we would run from our feelings. It was always reason, rationality. And for me, the heart was more important. So for me it was very difficult, but that was also the most painful.

The discourse of men as self-reliant and strong kept many of the men in this study from talking about their experiences. Like the other discourses, it ultimately made them suffer in silence.

Homophobia and heterosexism. Men's disclosure, specifically of sexual abuse, was also impeded by common social views of men as heterosexual and a general fear of homosexuality. Many of the male participants said their fear of being labelled as homosexual was one reason why they did not disclose any trauma-related difficulties,

particularly those stemming from sexual abuse. For example, Braveheart said that, “I didn’t tell anyone about the abuse. ... I was afraid, especially back then. ... I was afraid that someone would label me as a homosexual.” Similarly, Quasimodo said he did not tell any of his close friends or others about his abuse, “Because they think automatically you’re gay.”

The impact of homophobic discourses on men’s unwillingness to disclose their trauma or their trauma-related problems was exemplified by Michael, a gay man, who discussed being molested by his father: “And shortly after my mother died we were in the same bed sleeping, and I felt my father trying to feel me up. And I thought, oh god, he’s trying to find out [if I am gay].” When asked if he told anyone about it, Michael said: “No, I didn’t. Because I was still incredibly in the closet. I didn’t want to talk about my feelings, that side of my life to anybody.” Thus, Michael’s fear of being let “out of the closet” inhibited his ability to talk to others about his father’s molestation of him. Interestingly, Michael also used his homosexuality to rationalize his father’s behaviour and make it appear as something other than sexual abuse.

Thus, discourses of homophobia constrained the men’s ability to talk about their abuse because they feared being labelled as a homosexual or, in Michael’s case, having to admit his sexual orientation to his family.

As with discourses of femininity, discourses of masculinity had a negative impact on men’s willingness to talk about any problems they had as a result of their traumatic pasts. Moreover, unlike the discourses used by women in the study, the discourses that men drew upon were ones that served to underscore the unfound notion that men could not be victims.

Age-Related Discourses Relevant to Trauma

In addition to discourses of masculinity and femininity, examining participants' narratives revealed two prevailing discourses around aging and the aged that seemed to affect their (un)willingness to disclose or seek help for their trauma-related difficulties. In particular, and as shown in Figure 4, discourses that depicted older adults as too old to benefit from therapy or as being *lost causes* suggested to some participants that pursuing therapy was not worthwhile or justified because they "don't have long to live." Not surprisingly, this discourse impeded participant's willingness to seek further help from mental health professionals for their trauma-related difficulty.

Participants' narratives also revealed an age-related discourse that, as older adults, they had *nothing to prove anymore*. This discourse was related to the idea that participants, to a certain extent, had grown wiser with age and as such, cared less about what other people thought. This, in turn, facilitated their willingness to talk about their previous traumatic experiences. It may also explain participants' willingness to discuss their traumatic past openly with me during their interviews.

Figure 4. *Age-Related Discourses Relevant to Trauma*

Interestingly, there seems to be competing discourses that determine older adults' disclosure and help-seeking behaviour. Although the *lost causes* discourse inhibited disclosure and help-seeking, *nothing to prove anymore* facilitated it, particularly within the context of the interview. In particular, the participants expressed feelings of changing with age.

Lost causes. This age-related discourse involved the notion of the elderly as being "lost causes" in the sense that investing time and resources into therapy would be wasteful as they are going to "die soon anyway." In other words, society's devaluation of older adults due to their age and relatively limited lifespan constrained some participants' willingness to seek help. For example, Quasimodo's wife continued to discourage him from going to therapy, despite the ongoing difficulties he was struggling with due to the abusive events he experienced during his childhood: "And J:[wife] discouraged me because she says, "You're wasting your time. You've seen so many psychiatrists it's beyond belief. You've taken so many pills it's beyond belief. You're never going to change now." Unfortunately, Quasimodo faced the same type of sentiment from his family doctor:

I just take the pills and my family doctor takes care of everything, and he refers me to him [a psychiatrist] but, uh, last time I was talking to him and all that and he says, "You can take it, but it's not going to change anything." He says, "We talked about it, it's already set."

When asked what was already set, Quasimodo replied:

My anger. My emotions. And he [the family doctor] says, "Even if you talk about it [Quasimodo], you tried it before. It hurts. You don't want to go about it [talking about his traumatic past], so why waste your time?" So he says, "You can go if you want to, but it's just a waste of time. It's useless for you."

Indigo also believed that he was not being offered any therapy or support due to his age. When discussing being assessed for disability insurance because of the acquired brain injury that resulted from years of alcoholism, Indigo explained: “[The psychologist said] I was malingering, telling lies, and I was doing all these things, there’s nothing wrong with me, I should be back to work immediately. I basically felt that it was a waste of time and that I was a lost cause.” Similarly, Tulip said,

When you’re a little kid and you gotta climb up the stairs, somebody comes along and says, “Look at that cute little kid, trying to get up the stairs. I’ll just give,” you know, “give him a little push or whatever.” Well, you don’t see that anymore. You’re trying to get up the stairs, nobody wants to bother you ’cause you’re too much trouble.

Tulip’s use of metaphor reinforces the apparent influence that the “lost cause” discourse had on many of the participants.

Finally, when explaining why she does not seek any therapy for continuing problems stemming from her early abuse experiences, Ruth said:

I’ve pretty well run the gamut now and I realize I have to stay on medication for the rest of my life because I’m clinically depressed. I either get too high or I get too low. No, I don’t need no help. What’s the point? I’m 62 years old and lord knows, but I’ll probably be dead soon.

In summary, the “lost cause” discourse appeared to have impeded participants’ willingness to seek help or detracted from their belief that people were actually willing to help them.

Nothing to prove anymore. This discourse facilitated seniors’ willingness to talk to people about their trauma and, presumably, their willingness to take part in the interviews. For example, Ruth said, “So I think you just, now I’m older, I don’t care

anymore. I don't need to hide it because I've got nothing to prove anymore." Similarly, Lily said: "And I think I can accept myself better now than I ever could before. I don't feel I have anything to prove anymore."

Michael also described how aging helped him be more open about his past, which subsequently led to him feeling better:

I never come out and said, guess what? I just stopped pretending and it was a terrible pretense. I'm sure people have told you that before. It's terrible to say, "Oh, can I say this, can I do that? And what will they think?" Now I don't give a damn. And it's much healthier.

Tulip also alluded to the notion that she had nothing to prove anymore and how it was time to focus on her own issues:

All these roles I could do, I don't want them anymore. I just wanna be ... me. Upfront, crude if I feel like it.[...] I want to be around people where I can express myself, and they're not going to judge me. And if they do judge me, tough, that's their problem. I no longer care to ... to ... fix other people's problems like I used to. I wasted time and energy all of my life, fixing everybody's problems and not paying attention to my own, which is my own damn fault.

Increased confidence with age also seemed to play a role in participants' willingness to disclose their traumatic experiences. This was evident in their attempts to make new meaning out of their experiences and their dismissal of their earlier need to have other people's approval. For example, when asked if she felt weak now like she did when she was a child, Daisy responded "No, 'cause I'm a survivor." When I asked her to explain what has changed, Daisy said:

I just feel stronger. I've got more confidence in myself. I used to see myself go out with my first husband, and sit there, and be so petrified that somebody was going to come up and try to talk to me. That was from my upbringing. But then

gradually over the years - jobs I took, I had to talk to people, and it gave me confidence in myself.

Quasimodo also referred to himself as a survivor: “Well, I’m much more open than I used to be, you know. It’s like, this is gonna sound really stupid, it’s like a badge. You know? I survived it.”

Other participants noted that the opinions of others simply became less important. For example, Penny said, “I think as you get older you learn and what other people think becomes less important to a certain extent.” When asked if being older has affected how she views her past experiences and her willingness to talk to others about it, Penny explained:

Yes, I think so. I think you get older, you’re more experienced, you look at things a little differently, so Yes, yes. I think I’m more willing now to talk about it than probably when it was happening. ... Because I think I understand it more and understand myself more and maybe more comfortable with who I am now. When I had Wayne, I wanted him to be like everyone else’s child, ’cause I think all young mothers do. You gotta get your teeth at the same time, walk at the same time. But I was 38 when I had my youngest son and by then I just looked after him the way I thought he should be and I didn’t care what anyone else said, you know. So I think as you get older you learn and what other people think becomes less important to a certain extent.

Lucky articulated similar feelings:

I’d have to say that life experiences now have brought me around to the conclusion that, hey, everything’s admissible. Deal with it and interpret it the way you want, and I’ll argue it with you if you want, but previously, I was perhaps embittered, didn’t want to be scanned, or researched or whatever residual effects. Now, I don’t care.

Indigo said that aging in general made him more open: “It makes me more receptive [to

talking to others about my past].”

Finally, Ruth discussed how the time in her life has opened her up to talking about her traumatic experiences:

Yeah, I think maybe when you get older, you know, what the hell. Might as well. But it's not something you want to. ... I don't know, when you're younger it's not something ... like I tried to hide everything from my kids. I didn't want my kids growing up in the environment that I did. I didn't want ... you know that was horrible. I had to keep an eye on my girls 24/7 because I was so afraid a man was going to get at them. You know, when you're abused when you're younger, in any way and then you try to have a family of your own, this baggage comes with you, which you don't know. You put it in the back of your head. You get married. You're all happy. You're going to have your babies. It's a wonderful time in your life and I was happy. But damn if it doesn't keep creeping in. It keeps trying to get in as much as you try to no, no, no. First thing you know, you end up having panic attacks and you don't know where they're coming from. You want to kill yourself, you know. But it all stems from your childhood. Yeah it does. So I think you just, now I'm older, I don't care anymore.

Participants' discussion of aging and its effects suggest that although the experience of trauma and its aftereffects endure over time, aging positively affected their willingness and ability to confront their past experiences and talk about it.

Taken together, these age-related discourses suggest that social constructions of being old, under some circumstances, can impede or promote participants' willingness to talk about their trauma or to seek help. In particular, feelings around being “lost causes” made some participants feel as though any attempt to seek therapy would be a waste of time. This inhibited their ability to receive appropriate therapy that may have addressed some of the underlying causes associated with their childhood traumas.

On the other hand, the discourse of “nothing to prove anymore” served as a positive influence for many of the participants. This is evident primarily from their participation in the interview and their willingness to disclose their traumatic pasts with me.

Discussion

The present study was conducted to understand how senior women and men construe their trauma and their trauma-related symptoms and how this, in turn, affects their disclosure and help-seeking behaviour. As proposed by Alaggia (2010), the participants’ willingness to disclose previous traumatic experiences can only be understood within the context of ontogenic (e.g., personal history), micro-system (e.g., family environment), exo-system (e.g., community influences) and macro-system levels (e.g., cultural and societal attitudes). Consistent with this, the findings of the grounded theory and discourse analyses suggest that senior trauma survivors’ disclosure and help-seeking behaviour are affected by a complex interplay between the characteristics of the trauma they experienced, people’s reactions to their disclosures, and broader societal attitudes.

By the very nature of its methodology, this study does not establish causal relationships; nor was that the goal. However, based on the consistent themes inherent in these participants’ narratives, one can reasonably argue that these participants’ disclosure experiences significantly influenced their adjustment to, and coping with, their earlier traumatic experiences. Indeed, one of the most profound findings of the current analysis is the important role of people’s reactions to disclosures of trauma, particularly first disclosures, in mitigating the aftereffects of trauma such as shame and fear. Consistent

with research by Bolton et al. (2003) and Dikel et al. (2005), in the current study it was not simply the act of disclosure that affected participants' psychological well-being, but rather how family members, friends, and later professionals, reacted to participants' disclosure of the traumatic event. Thus, participants whose disclosures were disbelieved by family members and silenced into not discussing it further (e.g., Braveheart and Ruth) or who had their traumatic experience minimized (e.g., Peter and Tulip) continued to experience problems throughout their lives to the current day. This is in stark contrast to the experience of participants (e.g., Nadia, Gung Ho, Penny, Michael and Noah) who believed that they could speak freely about their traumatic experiences because others were going through the same thing (e.g., the Blitz in London during World War II) or because their family and friends were open to them discussing their trauma. These participants were doing relatively well and were relatively free of psychological challenges throughout their lives. That the negativity of the reactions to the disclosure is strongly related to the severity of psychological aftereffects is consistent with the research by Jonzon and Lindblad (2004) and Ullman (2003) on disclosure among sexual abuse survivors.

Importantly, a negative disclosure experience reinforced any feelings of shame and fear participants had as a result of their trauma, and ultimately contributed to the continuation and potential exacerbation of their trauma-related difficulties as well as continued nondisclosure and not seeking help across the lifespan. That these feelings become deeply ingrained is reinforced by Kaufman's (1992) work on the power of shame:

Shame originates interpersonally, primarily in significant relationships, but later can become internalized so that the self is able to activate shame without an

inducing interpersonal event. Interpersonally induced shame develops into internally induced shame. Through this internalizing process, shame can spread throughout the self, ultimately shaping our emerging identity. Prior to internalization, shame remains a feeling which is generated and then passes on, whereas following internalization, shame can be prolonged indefinitely. (p. 8)

That characteristics such as shame and fear impeded senior women and men's willingness to talk about their traumatic experiences and, at times, exacerbated the negative mental health outcomes associated with their traumatic experiences are findings that are entirely congruent with research on younger populations (e.g., Alaggia & Millington, 2008; Grossman, Sorsoli, & Kia-Keating, 2006; Ullman, Filipas, Townsend, & Starzynski, 2007). Ultimately, participants who experienced these effects had profound difficulty in talking about their trauma around the time it occurred. More striking, perhaps, is that these same dynamics continued to affect participants' willingness to disclose their traumatic experiences or seek help for their trauma-related problems during their senior years.

Consistent with the large body of research on trauma, especially child sexual abuse, and disclosure (e.g., Danieli, 1997; Hébert, Torigny, Cyr, McDuff, & Joly, 2009; Smith et al., 2000; Ullman and Filipas, 2005), a number of participants indicated that they had never told anyone about their childhood experiences of trauma. Notably, these participants were still experiencing psychological problems at the time of the interview, including PTSD, depression and anxiety.

The analysis also revealed that, by and large, these participants' attempts to seek professional help during adulthood and later life were affected by their earlier disclosure experiences, as well as the persistent failure of professionals to recognize the signs of

trauma. These signs included PTSD symptoms, panic attacks, suicide attempts and alcoholism. For the most part, these trauma survivors did not seek help prior to middle age and, for most, the therapy they did receive was focused on their marital difficulties or problems associated with alcoholism. Moreover, the fact that the participants who experienced chronic interpersonal traumas were still experiencing trauma-related aftereffects at the time of the interviews suggests that any trauma-related help they did receive was still inadequate (e.g., Braveheart, Indigo and Susan). While it is possible that these participants simply received therapy too late, Susan's experience with therapy in late-life and her subsequent self-proclaimed recovery suggests that seniors can be helped. These findings highlight the need for clinicians to be aware of the long-term effects of trauma and to ask older clients about any traumas they may have experienced. This is particularly important given that few mental health professionals are aware of the high rates of trauma such as sexual abuse in the history of their psychiatric patients (Donohoe, 2010).

The inability of participants to receive the help that they need suggests that participants' feelings stemming from their previous trauma may have been reinforced through a form of secondary victimization. Indeed, secondary victimization can occur when trauma survivors try to disclose their trauma or have their trauma-related problems ignored by those in the helping profession. Secondary victimization can also occur from a lack of social recognition and support (Vukusic et al., 2003). Secondary victimization by health professionals has been documented among female women survivors of sexual abuse (Filipas & Ullman, 2001; Ullman, 1996) and male war veterans (Vukusic et al., 2003) and further research has documented that secondary victimization that arises

through victim blaming or not receiving help can actually predict higher rates of PTSD and depression (for a review see Campbell et al., 2009). In light of this, as well as the comments made by some of the current participants, it is likely that some participants' psychological problems were exacerbated by the ongoing revictimization they experienced from healthcare professionals' lack of understanding.

The grounded theory analysis also indicated clearly that, despite the passage of considerable time, senior trauma survivors continue to endure the effects of earlier trauma. This is consistent with research on survivors of war-related trauma (Jongedijk et al., 1996; Rintamaki et al., 2009), the Holocaust (e.g., Amir & Lev-Wiesel, Brom et al. 2002) and violence against women and children (e.g., Allers et al., 1992; Wickett & Kristiansen, 2008). Although situational factors, such as the loss of independence and social supports, may well contribute to the distress of senior trauma survivors (Aarts & Op den Velde, 1996; Danieli, 1995; Krystal, 1995), to the extent that such stressors invoke feelings reminiscent of their trauma (e.g., powerlessness, betrayal, fear, isolation) they may be especially difficult for people who have not had the opportunity to work through their previous traumatic experiences.

The differential effects of gender socialization, a macro-system level factor (Alaggia, 2010), were evident in the participants' descriptions of their disclosure and help-seeking, both during childhood and later life. Survivors of trauma, particularly trauma related to sexual and physical abuse, described people's reactions to their initial disclosure as detracting from their ability to share their experiences with others (e.g., they were not believed, their abuse was minimized). As a result, the women and men in the current study turned to social cues to inform them of more appropriate ways of

understanding their experience. Among other things, these cues included the stereotype or expectation that men are unemotional and, consistent with this, many of the men in this study were unable to articulate their feelings following their traumatic experiences. Ultimately, this process was self-silencing. For example, a major obstacle to men's sense of legitimacy stems from society's failure to view men as victims. As a result, many male survivors cannot take their own traumas seriously.

In light of this, it is not surprising that many male trauma survivors minimize their trauma-related symptoms (e.g., Molinari & Williams, 1995) and do not seek help for their trauma-related difficulties, as observed in the current findings. Indeed, the findings of this study are congruent with an emerging body of research that indicates that men have difficulty disclosing sexual abuse or seeking treatment for it because men are socially constructed as being strong and not in need of protection (Alaggia & Millington, 2008). Moreover, in the face of such pervasive attitudes toward male victims, when men do come forward, they may have their experiences minimized, which can lead to further feelings of betrayal. Men's feelings of being perceived as "less than" may not be completely unfounded given recent findings that, relative to female university students, male students evaluated men who disclosed a history of child sexual abuse more negatively and judged male survivors of child sexual abuse as less likeable and less competent in therapeutic and work roles (Harter, Harter, Atkinson, & Reynolds, 2009).

The findings of the discourse analysis identified similar processes in older women's narratives. For example, some of the older women said they had been taught to regard "anger" as inappropriate for girls and women. Because their feelings of anger and rage at the perpetrator are discrepant with the social construction of femininity as

involving passivity, niceness and powerlessness, women may suppress these emotions and this, in turn, may exacerbate their feelings of helplessness and powerlessness. In contrast, anger is probably the only trauma-related emotion that does not contradict the social construction of masculinity. As a result, male trauma survivors may rely on anger as their sole emotional outlet, while denying their feelings of vulnerability and depression. Alternatively, the view of men as unemotional and inexpressive may inhibit male trauma survivors from outwardly displaying any emotional turmoil. Moreover, discourses of dominance that depicted men as self-reliant may compel older male trauma survivors to essentially suffer in silence. This is congruent with Sorsoli et al.'s (2008) qualitative research indicating that social constructions regarding masculinity acted as strong deterrents to the disclosures of 16 male survivors of childhood sexual abuse.

The women in this study also drew on discourses of women as sexual gatekeepers who have a responsibility to avoid their abuse. This finding is also consistent with a large body of research, this time research showing that women are often blamed for sexual offenses perpetrated against them (Crocker, 2005; Stahl, Eek, & Kazemi, 2010; Thapar- Björkert & Morgan, 2010) or perceive themselves as responsible for the abuse (Krause et al., 2002). As a result, “an environment of victim blaming and normalization of violence is created in which women feel unable to report crimes of violence against them” (Thapar- Björkert & Morgan, 2010, p. 38). This is particularly alarming in light of research that indicates that the negative effects of blaming are much more powerful than those associated with positive social support (Campbell, Dworkin & Cabral, 2009). Added to this, many of the women who survived sexual abuse used discursive strategies

that served to minimize the abuse they experienced. This minimization of abuse may well have made them less likely to disclose the abuse.

Similarly, social constructions of aging and the aged perpetuated negative attitudes and stereotypes that may not only detract from seniors' self-esteem and quality of life, but may also have detracted from the likelihood that they would disclose their trauma and seek treatment. In particular, discourses that construct older adults as "lost causes" due to their age, physical state and/or reduced mental competence suggest that older trauma survivors will not be taken seriously, and therefore detracted from their willingness to disclose their trauma or seek treatment. This discourse is consistent with that observed by Coupland and Coupland (1993), who found that people used discursive representations of age that were enmeshed with considerations of ill health. Accordingly, "such statements endorse a view of aging as an unremitting decremental process with expectable stages of decline in physical and emotional wellbeing linked to chronological aging" (Coupland & Coupland, 1993, p. 288). Such discourses, then, suggest that investing any time and energy in trying to heal older trauma survivors would indeed be a "waste of time."

Finally, the discourse of having "nothing to prove anymore" was the only empowering discourse that participants used to construct their disclosure experiences in later life. In many respects, this discourse offers a glimmer of hope because it signals that people can come to a time in their life when the pressures to prove things to others (e.g., their worth, their power) become secondary to the pressures of coming to terms with their past.

Taken together, these prevailing discourses around gender and age illustrate that everyday conversation or discourse can reproduce social injustices and inhibit effective intervention for older trauma survivors by detracting from their willingness or ability to discuss or seek help for their problems.

Interestingly, and as observed in other research (e.g., Wickett & Kristiansen, 2008), the psychological well-being of some of the senior participants (e.g., Daisy, Quasimodo, and Braveheart) was adversely affected by the extent to which they reminisced about their previous experiences. In Erickson's (1968) model of psychosocial development, successful aging requires find meaning and significance in one's life as it has been lived, a task that involves reminiscence. Some, however, may be unable to make sense of or finding meaning in their earlier experiences of trauma. As Shrira and Shmotkin (2008) explained:

When continuous, recently reactivated, or unresolved complications of trauma interweave with such frailty, it may be almost impossible to reach a reconciliation with, or an integration of, past upheavals. Indeed, traumatic memories have a far greater impact on mental health compared to positive memories, especially in cases of post-traumatic stress (p. 808).

For such people, reminiscence may be problematic in that it may lead to feelings of depression, guilt and obsessive rumination (Parker, 1995).

As if the potentially negative effects of reminiscence were not enough, a number of researchers (e.g., Kristiansen & Hay, 2000; Reich, 1996) have argued that aging in itself may replicate the dynamics associated with trauma, dynamics that include feelings of powerlessness, shame and betrayal (Finkelhor & Browne, 1985). Doctor-patient

power differentials or seniors' lack of credibility may, for example, instill feelings of powerlessness, while sexism and ageism may contribute to feelings of shame, and being neglected or abandoned by children or declining physical health may contribute to feelings of betrayal. Unfortunately, exposure to any situations that evoke emotions similar to those they experienced earlier during their traumatization (e.g., powerlessness via physical illness), and there are likely many of them, may play a key role in older trauma survivors' ongoing mental well-being.

It seems clear that the ability of older trauma survivors to overcome their fear and shame following their trauma was profoundly stunted by people's actual or feared negative reactions to their disclosures. As such, it follows that, from a tertiary prevention perspective, the single most important factor in improving the psychological outcomes of trauma survivors may simply involve having someone listen to them, validate their traumatic experiences, and assure them (directly or indirectly) that they are not to blame.

Understanding these discourses and how seniors draw upon them to construct their own experiences suggests ways in which health care professionals (e.g., psychologists, general practitioners) and laypersons (e.g., friends, families) can intervene. They may, for example, seek to disabuse female trauma survivors of the idea that sexual abuse only involves intercourse, a belief articulated by a number of the women in this study. This is important as it may help such older women draw the links between their previous trauma and their current psychological problems. Professionals and laypersons may also draw attention to the need to recognize that men can be and are victims and they may also work to create environments that facilitate older men's willingness to express emotions related to their abuse experiences.

Most fundamentally, the findings of this research draw attention to the need to restore older trauma survivors' faith in support. That is, they need to feel safe and confident that they will be taken seriously when they disclose their traumatic experiences. They also need to be assured that they will receive the help they desire when seeking help for their problems. This is particularly important in light of research regarding the revictimizing impact of healthcare professionals, as noted above (Filipas & Ullman, 2001; Ullman, 1996; Vukusic et al., 2003). Thus, gerontological, clinical, and medical training more generally might usefully draw professional caregivers' attention to the various reasons why older trauma survivors may be unwilling to talk about their experiences and the age- and gender-related discourses that they draw upon to understand their experiences. Such training might also be exploited to educate practitioners about the gendered nature of both trauma and the problems associated with trauma, and the need for gendered intervention efforts in view of this. One way to do this would be to ensure that gerontology is informed by feminism and postmodern theories that highlight the roles of the self, language and social action (Ray & Fine, 1999; Vinton, 1999). This could entail, for example, specialized training materials or guidelines on how to work with older women and men who have survived an earlier trauma.

Moreover, this training may equip healthcare providers to be better able to help older trauma survivors reframe the meaning of their traumatic experiences in ways that facilitate their disclosure, help-seeking and well-being. Finally, given research indicating that those who disclose their trauma-related experiences and symptoms have far better psychological and physical outcomes (e.g., Jonzon & Lindblad, 2004; Ullman, 2003), findings replicated here, this research reinforces the need to support trauma survivors at

the outset and for families and communities to be open and responsive to both the story of trauma and its aftereffects. Given that a number of participants articulated the notion that they had “nothing to prove anymore,” this research also suggests that there is an opportunity to capitalize on these feelings to promote more disclosure among older trauma survivors who are very likely willing to open up about their traumatic past.

The findings of this research may also be useful to older trauma survivors in more direct ways. It may, for example, help them understand some of the factors that may have inhibited their disclosure of their experiences and, thereby, facilitate their help seeking behaviour. More fundamentally, perhaps, there is a need to understand that “time does not heal all wounds” and changing societal attitudes toward trauma, particularly sexual abuse and aging, will go a long way in helping older adults come to terms with their past so that they can indeed enjoy what is supposed to be their “golden years.”

Given the paucity of research on senior trauma survivors and the long-term aftereffects of earlier trauma in late life, the current study points to a pressing need to further examine the long-term effects associated specifically with childhood sexual and physical abuse. In addition, given this study was on disclosure and help-seeking, it is conceivable that the very people who should take part in the study (i.e., non-disclosers and non-help seekers) are the ones not likely to respond to requests for an interview. Although three participants had indicated that they had never talked about their traumatic past until they had an opportunity to speak with me, future researchers should strive to specifically examine non-disclosers (to the extent possible) to understand their particular situations.

Moreover, although the current sample had representation from a variety of different backgrounds and ethnicities, future research should examine the impact of culture on disclosure and help-seeking. This is particularly important in light of the interview with Nadia, whose shame and guilt stemmed from cultural constructions of the importance of being a virgin upon marriage. Once she was assured of her virginity, the feelings that she had regarding her earlier sexual abuse seemingly disappeared.

Finally, future research focusing on a comparison between older trauma survivors who received either a positive or negative reaction to their disclosure would also provide insight into how society can better respond to the needs of these survivors.

As articulated by Ray and Fine (1999), “One of the most significant contributions of the feminist movement in and out of academe has been the validation of personal knowledge” (p. 175). The biggest strength of this study is that the findings are grounded in the voices and narratives of the participants. Through the more than 40 hours of interview time, participants were provided with an opportunity to provide a rich, insightful account of their experiences. I believe that this insight could not have been achieved through quantitative methods. However, as is true of all research, the validity of the findings and the recommendations generated from them are ultimately limited by the weaknesses of the research. Most notably, although qualitative researchers purposively sample participants for their experiences and the meaning they make of them, as opposed to quantity and issues related to statistical power or population representativeness, the self-selection of participants into the study remains problematic. Moreover, the findings of this study are likely limited by the fact that the very people I wanted to talk to (i.e., those who could not talk about their trauma) are precisely the ones

who would not participate in a study that required them to talk about their trauma. Hence the older trauma survivors who decided to participate in this study may be systematically different from those who are unwilling to talk about their trauma. In addition, and despite devoted attempts to recruit a diverse range of trauma survivors, no war veterans participated in the current study. That being said, it is clear that the current findings are only transferable to people who share the characteristics and experiences of the current participants.

Despite these limitations, the current research suggests that there is an opportunity to mitigate some of the longer-term negative outcomes of earlier trauma among older trauma survivors. If aging does in fact increase the willingness of some older trauma survivors to talk about their abuse, then service providers who work with them would be well advised to be sensitive to their desire to change and direct attention, efforts and resources toward them to help them make their desire a reality. Indeed, as articulated by Braveheart: “In life, what sometimes appears to be the end is really a new beginning.”

Personal Endnote

One of the difficulties in writing up qualitative research is making decisions about what parts of the participants’ narratives should be included. This thesis provides a small snapshot into the lives of 16 people who took a leap of faith in sharing their stories with me. Having been schooled in quantitative methods throughout most of my university career, I was profoundly struck by the power of talking to people and the knowledge that such conversations provided. I think this knowledge is deeper and more profound than the knowledge I could have gleaned from statistical analyses of mail-out questionnaires.

While I do not think that quantitative work is any less valid, I do believe that in the context of the current study, the use of qualitative methods was essential at getting at the type of information that I sought.

At times I found it difficult reading through certain passages in the participants' transcripts because I recalled the gut-wrenching emotion that some of them felt as they were talking to me. I also at times felt incredibly sad. Here were people who, for all intents and purposes, had struggled through life with heavy burdens as a result of being victims of unspeakable abuse and trauma. Having survived, despite most odds, they were once again in a position where society as a whole seemed to be failing them. I find this difficult to come to terms with and have vowed to myself, as a feminist and advocate for human rights, to ensure that the work that I do both academically and professionally serves to rectify this problem.

As a senior advisor in the federal government for a small human rights agency focused on women and girls' rights, for the last five years I have represented Canada at the United Nations Commission on the Status of Women, mainly as a negotiator. In 2013, for the first time in the history of the Commission (which has been in place since 1946), an outcome document on eliminating and preventing all forms of violence against women and girls was finally adopted by member states. This was no less than a Herculean effort, given the vast differences among the countries in the room; from those who invoked custom and tradition to justify violence against women and girls to those who condemned all forms of violence, including violence instigated during war. While at times it was easy for me to rest on the "laurels" of coming from a country with a relatively progressive view on these issues, I could not help but think of the survivors

who I interviewed and the problems they still face. I am continuously astounded by the persistently high rates of violence perpetrated against women and children in Canada. I am also continuously astounded by the fact that families, friends and health professionals find it difficult to believe that someone they know is being sexually or physically abused or bearing the burden of some other, unspeakable trauma. It is my hope that the voices of the women and men whom I interviewed will finally be heard, even if by a small minority, and that those people that can really make a difference (i.e., families, friends, health professionals) strive to make that difference.

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Appendix A

Research Materials

Interview Face Sheet**Participant No:** ____

Chosen pseudonym: _____

Age: _____ Gender: _____ Country of origin/ethnicity: _____

Relationship status: _____ No. of children: _____

Trauma(s): _____

Disclosed/discussed: Yes No If yes, to/with whom? _____**Received therapy:** Yes No If yes, from whom/when? _____

Type(s) of current psychological problems:

Type(s) of current physical problems:

Wants a summary of findings: Yes No**Willing to provide feedback on data interpretations:** Yes No**Call back completed:** Yes No***Interview*****Date:****Location:****Duration:*****Any notable features or comments:***

Interview Schedule

Participant No.: _____

A. Background

I'd like to begin by asking you why you decided to take part in this study?

Before we get to the details of the actual interview, I'd like to ask you some straight forward questions about your background.

- Date and place of birth
- Ethnicity
- Relationship status (i.e., single, married, divorced, etc)
- Number of children
- Are you currently being treated (through therapy, medication or otherwise) for any psychological, neurological or medical problems?

B. Traumatic Experiences

I know from the survey you filled out/our telephone conversation, that you experienced (type of trauma). Could you tell me a bit about that?

Potential probes:

- Who (no. of perpetrators, relationship to participant)?
- Did what (type of abuse, frequency, duration, force or violence, other aspects)?
- When (age at onset and offset)?
- At the time, how did you feel about having that experience? (e.g., did you feel ashamed, helpless, scared, horrified?)
- How did having those feelings make you think or feel about yourself?

C. Effects of Traumatic Experiences

- Did that experience have any effects on you, (emotionally or physically)? How did you feel about having those feelings/effects? What did that reaction make you think of yourself?
- What about now? How do you feel now about having had that experience? (e.g., do you feel ashamed or weak or anything like that?)
- How does having those feelings make you think or feel about yourself now?
- Does that experience having any emotional or physical effects on you now? How do you feel about having those feelings/effects? What does this reaction make you think of yourself?
- Have you experienced any other traumas besides (type of trauma)? If yes, reiterate B and C above.

I noticed on this survey that you completed, that you (e.g., never/rarely feel any anger, sadness). Can you tell me more about that?

- Don't you ever get annoyed or frustrated by people?
- Don't you ever feel sad?

D. Disclosure

Around the time the trauma occurred, did you tell anyone or talk to anyone about it?

(Probe: Did you talk to a friend or your spouse, for example?)

If yes: What motivated you to tell someone?

What was it like telling someone?

How did they react?

If no: At that time, did you ever think about telling someone about it?

What motivated you not to?

What about now? Do you ever tell anyone or talk to anyone about it now?

If yes: What motivates you to talk about it to someone now?

What is it like telling someone?

How do they react?

If no: Do you ever think about talking about it to someone?

What motivates you not to?

Possible probes:

- Who did you talk to? How often? How did they react/respond? Why?
- Did you talk about physical or psychological problems?
- What were the circumstances of your disclosure?
- How did it make you feel? How did having these feelings make you feel about yourself?
- Do you think it helped you? Why or why not?
- Did you ever feel the need to talk about your trauma but didn't? Could you describe an instance of this experience? How did you feel at that time?
- If never disclosed, why not? What do you think would happen if you did tell someone?

E. Help-Seeking

In the past, did you ever seek any help or treatment for any difficulties stemming from your experience?" (Probe: Did you talk to your family doctor, your pastor or a psychologist, for example?)

If yes: What motivated you to get some help?

What was it like going to someone for help? How did it make you feel?

What was it like having those feelings? How did having those feelings and needing help make you think of yourself?

How did they react?

If no: Did you ever think about getting help for some problems associated with your experience?

What motivated you not to? What did getting help make you think about yourself?

What did you think people would think of you if you went for help?

What about now? Are you, or have you thought about, getting some help for any difficulties stemming from your experience?

Additional possible probes:

- Who did you seek help from and for what? How often? How did they react/respond?
- Did you talk about physical or psychological problems?
- What were the circumstances of your help-seeking?
- How did seeking help make you feel? How did having these feelings make you feel about yourself?
- Do you think it helped you? How so?
- Have you ever sought formal counseling?
- If never received counseling, disclosed or sought help, why not? What do you think would happen if you did tell someone or sought help?
- How would you characterize a person who does seek help or treatment?

F. [For participants who never/rarely disclose or seek treatment when they probably should given answers to their symptoms questions above]

- What would you think about someone who told you they had experienced _____ (e.g., sexual abuse) and was feeling _____ (e.g., angry, depressed)?
- What do you think other people would think about that person?

G. Effects of Gender and Age

- Do you think that being a woman/man has affected your experience of the trauma/talking to others about it/help-seeking (then/now)? How so? How did this make you feel?

- Do you think being older has affected how you view your traumatic experience/talking to others about it/help-seeking? How so? How does this make you feel?

H. Conclusion

- People say that every cloud has a silver lining. Are there any lessons you have learned from your experiences, or has anything good come out of those experiences?
- Is there anything else you would like to talk about? Anything you think I should know?
- Do you have any questions about the interview or anything else?

I. Go through debriefing

- Go through debriefing form.
- Ask the participant for their chosen pseudonym.
- Ask the participant if s/he would be willing to provide feedback on the extent to which my interpretation of the data applies to them.
- Ask the participant if s/he would like a summary of the findings once the research is finished – get mailing address if yes.
- Ask if s/he would be willing to complete Foa's measure of PTSD and return by mail – if yes, give measure and stamped, addressed envelope
- Pay participant and have them sign for the money. Give thank you card.

Post-Interview Comment Form**Participant No.:** ____

Feeling/Mood/Tone of the overall interview:

Participant's reactions (emotions, body language, etc.):

My emotional reactions to the participant:

My emotional reactions to what the participant said:

Strong points of the interview:

Weak points of the interview:

Other notable features or comments:

Traumatic Events Scale

Part 1

Many people have lived through or witnessed a very stressful and traumatic event at some point in their lives. Below is a list of traumatic events. Put a checkmark in the box next to ALL of the events that have happened to you or that you have witnessed.

Serious accident, fire, or explosion (for example, an industrial, farm, car, plane, or boating accident)

Natural disaster (for example, tornado, hurricane, flood, or major earthquake)

Non-sexual assault by a family member or someone you know (for example, being mugged, physically attacked, shot, stabbed, or held at gunpoint)

Non-sexual assault by a stranger (for example, being mugged, physically attacked, shot, stabbed, or held at gunpoint)

Sexual assault by a family member or someone you know (for example, rape or attempted rape)

Sexual assault by a stranger (for example, rape or attempted rape)

Military combat or war zone

Sexual contact when you were younger than 18 with someone who was 5 or more years older than you (for example, contact with genitals, breasts)

Imprisonment (for example, prison inmate, prisoner of war, hostage)

Torture

Life-threatening illness

Other traumatic event. If yes, specify the traumatic event below.

**IF YOU MARKED ANY OF THE ITEMS ABOVE, CONTINUE.
IF NOT, STOP HERE.**

Part 2

If you marked more than one traumatic event in Part 1, put a checkmark in the box below next to the event *that bothers you the most*. If you marked only one traumatic event in Part 1, mark the same one below.

Accident

Disaster

Non-sexual assault by family or someone you know

Non-sexual assault by a stranger

Sexual assault by family or someone you know

Sexual assault by a stranger

Combat

Sexual contact under 18 with someone 5 or more years older

Imprisonment

Torture

Life-threatening illness

Other

In the lines below, briefly describe the traumatic event you marked above.

Below are several questions about the traumatic event you just described above.

How long ago did the traumatic event happen? (circle ONE)

- 1 Less than 1 month
- 2 1 to 3 months
- 3 3 to 6 months
- 4 6 months to 3 years
- 5 3 to 5 years
- 6 More than 5 years

For the following questions, circle **Y** for **Yes** or **N** for **No**.

During this traumatic event:

- Y N Were you physically injured?
- Y N Was someone else physically injured?
- Y N Did you think that your life was in danger?
- Y N Did you think that someone else's life was in danger?
- Y N Did you feel helpless?
- Y N Did you feel terrified?

Part 3

Below is a list of problems that people sometimes have after experiencing a traumatic event. Read each one carefully and circle the number (0-3) that best describes how often that problem has bothered you **IN THE PAST MONTH**. Rate each problem with respect to the traumatic event you described in Item 14.

- 0 1 2 3 Not at all or only one time
 - 1 Once a week or less/once in a while
 - 2 2 to 4 times a week/half the time
 - 3 5 or more times a week/almost always
- 0 1 2 3 Having upsetting thoughts or images about the traumatic event that came into your head when you didn't want them to
- 0 1 2 3 Having bad dreams or nightmares about the traumatic event
- 0 1 2 3 Reliving the traumatic event, acting or feeling as if it was happening again
- 0 1 2 3 Feeling emotionally upset when you were reminded of the traumatic event (for example, feeling scared, angry, sad, guilty, etc.)
- 0 1 2 3 Experiencing physical reactions when you were reminded of the traumatic event (for example, breaking out in a sweat, heart beating fast)

- 0 1 2 3 Trying not to think about, talk about, or have feelings about the traumatic event
- 0 1 2 3 Trying to avoid activities, people, or places that remind you of the traumatic event
- 0 1 2 3 Not being able to remember an important part of the traumatic event
- 0 1 2 3 Having much less interest or participating much less often in important activities
- 0 1 2 3 Feeling distant or cut off from people around you
- 0 1 2 3 Feeling emotionally numb (for example, being unable to cry or unable to have loving feelings)
- 0 1 2 3 Feeling as if your future plans or hopes will not come true (for example, you will not have a career, marriage, children, or a long life)
- 0 1 2 3 Having trouble falling or staying asleep
- 0 1 2 3 Feeling irritable or having fits of anger
- 0 1 2 3 Having trouble concentrating (for example, drifting in and out of conversation, losing track of a story on television, forgetting what you read)
- 0 1 2 3 Being overly alert (for example, checking to see who is around you, being uncomfortable with your back to a door, etc.)
- 0 1 2 3 Being jumpy or easily startled (for example, when someone walks up behind you)

How long have you been experiencing the problems that you reported above? (circle ONE)

- 1 Less than 1 month
- 2 1 to 3 months
- 3 More than 3 months

How long after the traumatic event did these problems begin? (circle ONE)

- 1 Less than 6 months
- 2 6 or more months

Part 4

Indicate below if the problems you rate in Part 3 have interfered with any of the following areas of your life DURING THE PAST MONTH.

Circle **Y** for **Yes** and **N** for **No**.

Y	N	Work
Y	N	Household chores and duties
Y	N	Relationships with friends
Y	N	Fun and leisure activities
Y	N	Schoolwork
Y	N	Relationships with your family
Y	N	Sex life
Y	N	General satisfaction with life
Y	N	Overall level of functioning in all areas of your life

Appendix B
Participant Profiles

Braveheart

Braveheart was a 64-year-old man who was sexually abused by other boys from the age of eight until he was 14 years old. He would go to a local race track and exercise a family friend's horse. Over a period of two summers, Braveheart was sexually abused by an 18 year old boy who worked at the stable. When he was ten, he was sexually abused by another teenage boy who forced him to perform oral sex. A number of other boys sexually abused him until he was 14 years old. Braveheart was physically threatened and warned not to tell anyone about the abuse. Braveheart also endured years of physical and emotional abuse as a result of teasing from other children about what happened to him at the stable. He described a childhood filled with anger and violence, including violence perpetrated by himself (e.g., he would get in fights with other boys who were teasing him).

Braveheart tried to tell someone about the abuse he was experiencing on three different occasions. When he was 10 years old, he told the principal of his school that he was being abused and the principal told him he was "making up stories." At the age of 14, he told his mother about the sexual abuse and she denied that that could happen to him. A few years later he tried to tell his Minister, but was simply told that the "military would do me good."

At the age of 32, Braveheart started having panic attacks, attacks that were first triggered by being in a barn with the smell of horses. According to him, that was the beginning of his flashbacks, although he did not know it at the time. He became an alcoholic. As a business owner, he began to steal money from customers, resulting ultimately in a jail sentence of 9 years, of which he only served one "for being a model

prisoner.” He started seeking professional help at the age of 56. He described years of trying to seek help from psychologists and psychiatrists for his trauma-related problems. Despite this, at the time of the interview, Braveheart was still in therapy and clinically diagnosed with Obsessive Compulsive Disorder, Post-traumatic Stress Disorder and experienced panic attacks. He was in a support group for men who had survived sexual abuse. Physically, he suffered from deteriorating discs in his back and arthritis, both of which were moderately debilitating.

Divorced twice, Braveheart was living alone, in poverty, in a boarding house where he shared a bathroom with other residents.

Cinderella

Cinderella was a 66-year-old woman who experienced sexual, physical and emotional abuse as a child. At the age of 5, she was molested by a teenage boy in a barn. She immediately told her brother what happened to her, but he was only three years old at the time. At age 10, her father started to sexually abuse her and she was abused by a number of adolescent boys in her neighbourhood who forced her to masturbate them. She was also raped by her boyfriend at the age of 17. At the same time, Cinderella described her mother as being emotionally and physically abusive toward her for most of her life. She said she felt “rejected” by her mother.

As a child, besides telling her brother about the one incident when she was five, Cinderella did not tell anyone about the abuse she was experiencing. She said she did not want to tell her mother “because she would have been blaming me.” She first started talking about the abuse at the age of 62 when she confided in a friend. Cinderella first sought out therapy in her late 20s as a result of her marital problems, stemming mainly from her husband’s alcoholism. She said that her history of sexual abuse was never discussed. From the age of 32 to 35 years, Cinderella saw a priest for counselling regarding issues related to her relationship with her mother.

Throughout her adulthood, Cinderella saw a variety of mental health professionals regarding her relationship with her mother. However, it was not until her later years that she started receiving therapy for problems stemming from her experiences of sexual abuse.

At the time of the interview, Cinderella was living in a co-operative apartment, and living off funds provided by a disability support program. She was estranged from

her children. She was facing eviction from her apartment due to problems with hoarding. The condition of her apartment clearly showed that she was a hoarder. I could only access the apartment through a small path, walled by boxes, books and other items. Her bedroom was so full of boxes and bags that she had to sleep on the couch in the living area. Her entire kitchenette was filled with papers and boxes, including both inside and on top of the stove.

Psychologically, she was experiencing depression, posttraumatic stress symptoms, anxiety and was diagnosed with Borderline Personality Disorder. Physically, she was suffering from respiratory problems, high blood pressure and arthritis.

Daisy

Daisy was a 61-year-old woman who endured ongoing child physical and emotional abuse at the hands of her mother. This abuse started when Daisy was an infant and lasted until she left home at the age of 18. Daisy said her mother would beat her once or twice a week and that the “beatings were unmerciful.”

When Daisy was 13 months old, her mother punched her on the side of the head. Daisy was paralyzed for a week and the right side of her body stopped growing. As a result, she has a permanent physical disability, with one leg and arm being smaller than the other. Daisy’s father left when she was ten. The night he left he threatened to shoot Daisy, her mother and her five siblings. She hid with her siblings in a closet all night until her father finally left.

Daisy was married twice. Her first marriage produced three children – two sons and a daughter. Her second husband battered her. She left him after she discovered that he tried to molest her daughter. Daisy also attempted suicide at that time. One of her sons died of HIV a few years prior to the interview and Daisy nursed him during his illness.

As a child, Daisy never told anyone about the abuse she experienced at home because, as she put it, it seemed “normal.” She talked about it with her sisters (who were also abused) for the first time at age 23. The only professional Daisy talked to was when she tried to commit suicide at the age of 36. She said she had difficulty talking to the psychiatrist at that time because he was a stranger. She discussed her past with her current boyfriend, but otherwise did not talk about her experiences with anyone, beyond her sisters.

At the time of the interview, Daisy was raising one of her grandchildren. She lived in a small, impoverished two bedroom apartment and was clearly struggling to make ends meet. Although she did not indicate having any psychological problems, she did have borderline diabetes, osteoporosis and high cholesterol.

Gung Ho

Gung Ho was a 66-year-old man who experienced the death of loved ones during his childhood. At the age of five, his father was killed when he was thrown from a horse. At the age of 16, his best friend died from a freak accident at a park, which Gung Ho witnessed. Following that, his cousin was killed in a car crash. In his mid-thirties, his brother died six months after being hit by a car. Gung Ho took responsibility for his brother's son and daughter. While his brother's 5-year-old son was vacationing in the Bahamas with his mother and grandmother, a cement wall fell on him and killed him. Gung Ho said he had to identify his body and that his death was the most traumatizing experience of his life.

Following each of these traumatic experiences, Gung Ho described receiving extensive support from his mother, wife, family and schools ("the teachers rallied around me"). As an adult, he became depressed following the death of his nephew and sought professional help. He was put on antidepressants and self-diagnosed bipolar disorder. When asked if he felt at ease talking about his past, Gung Ho said,

Now if you sit around in that room, and talk about it for an hour or two, I think that's healthy, and then go out for a cross-country ski, or go out for a walk, or go out for something. That's the way I dealt with it and that, I think, is good Aristotle moderation.

At the time of the interview, Gung Ho was in a relationship and still teaching classes at a university in economics. Aside from his bipolar disorder, he reported no other psychological or physical problems.

Indigo

Indigo was a 62-year-old man who was physically abused and neglected as a child. Between five and seven years of age, Indigo's mother had tuberculosis and was hospitalized for two years. Because his father was away in the airforce, Indigo and his four siblings were separated and placed in different homes for this two year period. During this time they were unable to see each other and their parents. From his perspective, Indigo "was basically an orphan." Compounding the trauma of being separated from his family, Indigo was beaten and neglected by the woman who played the role of his foster mother. He said he never told anyone about the abuse or neglect, not even when he was reunited with his family.

Indigo described having panic attacks in his 40s and 50s, which he thought were the onset of heart attacks. He said that he was a severe alcoholic for decades, which left him with an acquired brain injury through drunken falls and what he estimates to be "over 400 blackouts" from drinking.

At the age of 52, Indigo had what he called a "very intense psychic experience on a spiritual level," which resulted in him pouring his bottle of alcohol down the drain. Following that, he enrolled in Alcoholics Anonymous meetings. It was the first time he received professional help for his psychological problems. This entailed 10 years of seeking proper treatment and diagnosis which, according to Indigo, was often frustrating because his problems were attributed to his dementia and alcoholism. After seeing several doctors, psychiatrists and psychologists, Indigo finally found a psychiatrist who helped him open up about his past and address his posttraumatic stress disorder. He had been seeing him for the 5 years prior to the interview.

At the time of the interview, Indigo was living with his wife. He was experiencing PTSD, depression, anxiety, dementia and the complications of an acquired brain injury. He did not report any physical problems other than degenerative disc disease.

Lily

Lily was a 70-year-old woman whose uncle tried to molest her when she was 13-years-old. He had cornered her in a room in the basement and started to touch her. She said she was both frightened and angered. She was able to push past him and run to safety.

Lily indicated that she never told anyone about the incident because it did not escalate into a full “sexual assault” and “you know, we were expected to get out of these situations.” Following the incident, she said she had trust issues, but generally was unaffected by the encounter.

Lily described the divorce of her parents as one of the more traumatic events in her life. This occurred when she was a young child. In addition, Lily had to institutionalize one of her own children at the age of 3 due to severe cognitive impairments. She also had a son who was diagnosed with multiple sclerosis at the age of 19. Following this, she divorced her first husband.

When asked if she ever talked to anyone about these experiences, Lily replied, “There’s no sense really doing too much about it or saying too much to anybody because you need to deal with it yourself, you need to deal with how you feel about it.” However, she did indicate that she had a large network of friends with whom she discussed her worries and that this helped her through her more stressful times.

At the time of the interview, Lily lived in a condominium with her second husband and appeared to be happy. She reported no psychological problems. Physically, she only reported having high cholesterol.

Lucky

Lucky was a 72-year-old man who survived a life-threatening illness as a child, Guillain-Barré syndrome. According to Lucky, this syndrome resulted in nerve paralysis, which attacked his spinal cord and interfered with his motor skills. It left him paralyzed in a hospital for a year, from the age of 13 to 14 years. During the first three months of his stay, he thought he was going to die. He described an incident where a group of doctors was examining him and one of the doctors ran his thumb across his neck, indicating to another doctor that Lucky was going to die. Asked how this made him feel, Lucky responded, "My response to that was anger. It didn't depress me at all, I was very angry [...] it hardened my determination to exist."

Lucky said that he never discussed this incident with his family because they all expected the worst to happen. He also felt that he was going to overcome the illness, so did not feel the need to discuss it further.

Although his recovery from the illness was long, Lucky indicated that it played a large role in his lifelong competitiveness and his belief that he could overcome anything if he just put in the time and effort. He said this had some effects on his personal relationships, but that the sacrifices were worth it.

At the time of the interview, Lucky reported that he had never had the need to see a psychologist or psychiatrist for any psychological problems. He also did not report any physical ailments. In fact, he said he was training to run in a marathon in the coming months.

Michael

Michael was a 79-year-old man who lived through the 'blitz' in London during the Second World War. From the age of 11 to 15 years, he said they were bombed on and off. On one occasion, a bomb landed on the roof of his house. Although the house survived the attack, Michael described the experience as traumatic, especially because other people had been killed. When there was a bomb attack, he and his family would sleep in the underground tube with hundreds of other people. Michael described the times in the underground tube as fun for him as a young teenager. He said, "It was jolly to me."

Michael described a home life where his father was physically abusive. He said that as a result of this abuse, he hated his father. Michael's mother died when he was 15-years-old. Shortly afterward, when he was sleeping in the same bed with his father, Michael said "I felt my father trying to feel me up. And I thought, oh god, he's trying to find out [if he were gay]. So I just sort of smirked, turned and pretended I was sleeping." Michael said he did not tell anyone about the incident because he was worried about people finding out that he was gay. Moreover, he indicated that he did not talk about it until well into his later life.

At the time of the interview, Michael was living in an upscale apartment with his same-sex partner of 30 years. He did not report any mental health issues and physically he suffered from arthritis.

Nadia

Nadia was a 78-year-old woman who was sexually abused and raped at the age of five or six by a 20-year-old man who was staying in her parents' house. He would lead her into the gardens of the house or go into her room when her parents were not around. On one occasion, when Nadia was crying, the man threatened to kill her parents if she said anything. She never told anyone about the abuse at that time:

I grew up thinking I was terrible. All that time, from the age of 7 until the time I told my mother, I was always kind of depressed and thinking and especially when people come and ask my dad for marriage.

As an adolescent living in Lebanon, Nadia said she was ashamed of not being a virgin and believed that no man would marry her. Nadia said this weighed heavily on her and she vehemently refused the affections of any boys.

At the age of 18 years, she finally told her mother. Her mother took her to the doctor who said she was still a virgin. Nadia said, "That eases my life. I was happy to hear that and my mother said, 'You didn't do anything wrong. He's just a bully. He's bad.'" Nadia described both the doctor and her mother as being very supportive during that time and said she felt "purified." She said that since that day 60 years earlier, she had never told anyone about the abuse until she divulged it to me.

Nadia went on to describe an affluent and happy life, raising three boys and being part of her husband's very successful business ventures. At the time of the interview, Nadia had been widowed for two years. She was living in her upper-middle class home, alone. She said that because she was alone she was starting to think more about what happened to her as a child, particularly given stories that she saw on the news. Psychologically, according to Nadia, she was depressed (although not officially

diagnosed), which stemmed mainly from the loss of her husband. She reported no physical problems.

Noah

Noah was an 83-year-old Holocaust survivor. Born in Hungary, he was incarcerated in a forced labour camp at the age of 17. At the same time, his sisters had been sent to the Auschwitz concentration camp. He lost several family members. Noah said that it was not the forced labour that was difficult, but rather the stress of not knowing the fate of his family: "The forced labour didn't affect me so much because my mind wasn't there. It was hard, but my mind wasn't there with me. It was the uncertainty. What is with the family?" Noah escaped from the camp after 11 months and returned to Budapest to be with his wife.

At the end of World War II, Noah spent five years in the military, as required by law. Following that, he started to manage a salami factor and settled into life with his wife and young son. In his mid-twenties, Noah was sentenced to 20 years in prison in Hungary on false charges because he was Jewish. He only served 2 years of that time due to his wife's relationship with a high profile woman who had influence over the Justice system.

When asked how those experiences affected him, Noah said that everyone had gone through the same trauma and "shock." Noah went on to explain how he did not feel like he needed to talk to anyone about any stress or trauma-related problems because he did not feel he had any: "I didn't feel that I had any stress, you know."

Noah and his family eventually emigrated to Canada where he became the owner of a small art gallery. At the time of the interview, Noah was widowed. He was living in an upscale condominium and indicated that he had close ties with his family. He did not

report any psychological problems. Having survived lung cancer twice, Noah reported that he was seeing his doctor once again for cancer-related issues.

Penny

Penny was a 74-year-old woman who lived through the World War II Blitz in Britain, from the age of 5 to 6 years. Penny described this experience as “normal.” She did indicate that she would be nervous or sad on occasion, but otherwise she reported not being overly affected by the experience.

The mother of 8 children, Penny went on to describe how her oldest child was brain-damaged at the age of 2 years as a result of a bus accident. This resulted in years of Penny having to care for her son, which, according to her, she did at the expense of attending to her other children. She described this experience as far more troublesome than living through the war in Britain.

In terms of help-seeking, Penny indicated that she spent quite a bit of time over the years in family counselling for her son. She said she was not against talking to a psychologist, but never felt the need to do so.

At the time of the interview, Penny lived in a middle-class neighbourhood, alone. She did not report having any psychological problems. She was experiencing certain physical ailments, such as high blood pressure, acid reflux disease, and diverticulitis, but was otherwise in good health.

Peter

Peter was a 78-year-old man who was incarcerated in a concentration camp in Indonesia during the Second World War (occupied by Japan) from 11 to 14 years of age. He indicated that of his 15 brothers and sisters, only six survived the war. Both of his parents were also killed.

Peter described years of starvation, abuse and fear of dying in the camps. He regularly witnessed the torture and murder of his young friends at the hands of the Japanese soldiers, as well as the rape of girls and young women. He also described the older men in the camps trying to rape the young boys, including himself. He described the experience as dehumanizing.

Following his release from the camp, Peter stayed in a special protective camp for orphans until the age of 16. He then returned to Holland where, being an orphan, he was taken in by his aunt. He described feeling completely displaced during this period. He was unable to talk about his trauma because he said that many perceived his situation as less severe than the ones faced by Jewish people in Europe. He said, "So you find yourself becoming a non-citizen of almost anything."

Although he started to receive counselling around the age of 50, this was due to his marital difficulties. Peter described a life-long struggle with talking about his experiences, which to him were compounded by feelings of guilt and responsibility.

At the time of the interview, Peter was living alone. He was experiencing symptoms of PTSD, anxiety and depression. He indicated that he had been suicidal a couple of months prior to the interview. He was scheduled for knee surgery in the months following the interview and he explained that he was in severe pain. Peter talked

about how he was still striving to deal with his traumatic past. A retired pastor, he spent most of his life helping other people, but found it difficult to seek help himself. Just prior to the interview, he had successfully published a book about his incarceration in the work camps. According to him, this exacerbated some of his feelings of fear.

Quasimodo

Quasimodo was a 63-year-old man who was sexually abused by a variety of strangers as a child and physically abused by his father. At the age of six, Quasimodo was playing at the back of a store when a man forced him to perform fellatio on him. Quasimodo immediately went into the store to tell his father what had happened and his father replied, “I don’t want you ever to say anything about that again, not even to your mother.” He said this reaction profoundly affected the rest of his life.

At the age of 12, Quasimodo was hitchhiking and the man who picked him up took him back to his house under the pretence of getting his help unloading groceries. Once inside, the man undressed Quasimodo and masturbated him. At the age of 15, one of his father’s friends attempted to molest him in his bedroom, but Quasimodo made him stop.

In addition to the sexual abuse he experienced at the hands of strangers, Quasimodo’s alcoholic father started beating him when he was about four-years-old. These beatings continued until Quasimodo was 16-years-old.

At the time of the interview, Quasimodo expressed extreme sadness, depression and anger that he said stemmed directly from his experiences of abuse as a child. He also said that he often had suicidal thoughts. Although he sought professional help at various times throughout his adulthood, he said that none of these helped him because “I could never dwell deeply in it, because it hurt so much.” His issues were very much unresolved at the time the interview occurred.

Quasimodo lived with his wife and was estranged from his one son. At the time of the interview he had been diagnosed with prostate cancer. He was also suffering from

diabetes, high blood pressure and arthritis. Psychologically, Quasimodo experienced anxiety and had PTSD, as indicated by his PDS scores.

Ruth

Ruth was a 63-year-old woman who was sexually and physically abused by family members and friends throughout her childhood. She was first sexually abused by a family friend when she was five-years-old. He molested her in the bedroom on one occasion and stopped after Ruth told her mother about the abuse. Although her mother disbelieved her disclosure, the man moved out of the house. She was also molested by her uncle on one occasion. Ruth described horrific physical abuse by her father that began when she was approximately 12 years old and lasted until she left the house at 17 years of age. She also said that her father sexually abused her younger sisters and physically abused her brothers, although he did not sexually abuse her.

Ruth first talked to a psychiatrist about her childhood abuse after attempting suicide at the age of 44 (she also attempted suicide at the age of 54 and had suicidal thoughts throughout her adulthood). She first sought help from a psychiatrist in her early 30s when she started to experience panic attacks after the death of her sister. She was never asked about her past. Throughout her adulthood, she experienced depression and panic attacks. At one point, she was diagnosed with agoraphobia, although she indicated that the agoraphobia had abated.

Although Ruth said she had told her husband and children about her abusive childhood, when specifically asked who she disclosed to as a child or as an adult, Ruth replied, "I've told you stuff today that I haven't told anybody." Ruth explained that she was selective in the information she told her psychiatrist because "Maybe I was ashamed of it and never thought of it that way. Not that it was my fault, but maybe I thought he would have thought bad of me."

At the time of the interview, Ruth was living with her daughter and her family, as she was unable to afford to live on her own and she was afraid of being by herself. She was suffering from depression and continued to have suicidal thoughts which, according to her, were due to the fact that she had been widowed eight years prior and was unable to overcome the grief of losing her husband. Physically, Ruth was experiencing high blood pressure, high cholesterol and had recently needed to get a pacemaker.

Susan

Susan was a 72-year-old woman who was sexually abused by a neighbour as a young child and neglected by her parents. At the age of three, she would visit (alone) a man and woman who lived next door to her parents. During the visits, the man would sit Susan on his knee and put his finger up her vagina. When she was almost four, the man lured her to the barn to see some kittens and raped her. She said she can remember “absolutely searing pain.” She ran home to tell her parents and she described how most of the time was spent trying to keep her father from going over “to kill the man.” No one ever asked her how she was doing. Susan said this was one example of the many years of neglect she experienced as a child. She described a childhood devoid of any parental concern, love or affection. She also said her father was an alcoholic, which contributed to the dysfunctional family environment.

At the age of 15 Susan went on trip to England, where she was molested by a man with whom she was staying. She said it happened twice during the week that she was staying at the home. She never told anyone about this.

Susan was married to her husband for 45 years. For most of those years, her husband was an alcoholic. Susan saw psychologists and psychiatrists throughout her adulthood to both deal with her husband’s alcoholism and her own issues related to her traumatic experiences. The first time she saw a psychologist was for marriage counselling in her early 30s. Susan described the help she received from the many psychologists and psychiatrists she saw as being “useless” because they did not understand the underlying issues related to her earlier trauma.

At the time of the interview, Susan was living with her husband in their home in a middle-class neighbourhood. She was in therapy for issues related to her traumatic experiences as a child. She had several binders on her shelf that provided information on her “therapeutic journey.” She was officially diagnosed with PTSD by her psychiatrist. She also indicated that she experienced both dissociation and depression. Physically, Susan suffered from irritable bowel syndrome.

Tulip

Tulip was a 65-year-old woman who was sexually abused by her father starting around the age of seven when her father would touch her inappropriately (e.g., pinch her nipples) and expose his genitalia to her. This was ongoing until her parents divorced when she was 14-years-old. During that time she was also sexually molested by her aunt's boyfriend. Her mother remarried when Tulip was 14-years-old and her stepfather also sexually abused her until she left the house at the age of 16. Tulip described a dysfunctional household, with an alcoholic and physically abusive mother.

Tulip was married and divorced four times. She married for the first time at the age of 19 and had her one and only daughter. After two short subsequent marriages, she married her fourth husband who battered her for years. She likened the abuse she endured to the situation portrayed in the movie "The Burning Bed" where the woman endured horrific physical and psychological abuse at the hands of her husband. At the end of the movie, the character set her husband on fire while he slept because she saw it as her only means of escape. Tulip said, "I don't know how many times I had thought the only way that I'm gonna get out of this is if I do it when he's asleep."

During this marriage, she battled her husband's alcoholism as well as her own. She started attending Al-Anon meetings at the age of 43. Shortly afterward, she went to a women's shelter to escape the abuse upon the urging of a woman she met during her Al-Anon meetings. During her stay at the women's shelter, she recovered memories of her childhood abuse.

As a child and adolescent, Tulip did not tell anyone about the sexual abuse she endured as a child. She did not disclose to anyone the fact that she was being severely

abused by her husband until she sought help for her alcoholism. During the Al-Anon meetings, she began telling her stories of abuse, which subsequently prompted her stay in a women's shelter.

In terms of help-seeking, Tulip indicated that she had seen a psychiatrist about her panic attacks three years prior to going into a shelter for abused women. She said she never talked about the abuse with that doctor because it "was all blocked." When asked if she talked to her family physician about being suicidal, she replied, "I can't. Yesterday, I was suicidal ok? You think I can tell my doctor that?" Aside from her Al-Anon meetings in her early 40s and her stay at the women's shelter, Tulip indicated that she did not talk to anyone about the abuse she experienced either as a child or as an adult. When further pressed as to why she did not talk about it, Tulip stated, "Because I don't feel like they understand, that's why."

At the time of the interview, Tulip was living in her own house, alone. Although she owned her house, she lived in poverty, relying on a meagre pension and benefits from a disability support program. Psychologically, Tulip was suffering from panic disorder and depression. She indicated that she had suicidal thoughts as recently as three days prior to the interview. Tulip also had Cardio-Obstructive Pulmonary Disease (COPD), for which she required an oxygen tank, and rheumatoid arthritis. Both of these physical health problems were debilitating.