

Master of Clinical Science

**Health professionals' experiences with older adults
affected by the trauma of their childhood sexual abuse:
A systematic review of text and expert opinion.**

Marilyn Dodd RN, BA (Applied Statistics)

Student Number: 1214692

The Joanna Briggs Institute

Faculty of Health Sciences

The University of Adelaide

marilyn.dodd@adelaide.edu.au

Date: Sunday, 30 September 2012

Thesis Declaration

This work contains no material which has been accepted for the award of any other degree or diploma in any university or other tertiary institution to Marilyn Dodd and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text.

I give consent to this copy of my thesis, when deposited in the University Library, being made available for loan and photocopying, subject to the provisions of the Copyright Act 1968.

I also give permission for the digital version of my thesis to be made available on the web, via the University's digital research repository, the Library catalogue, the Australasian Digital Theses Program (ADTP) and also through web search engines, unless permission has been granted by the University to restrict access for a period of time.

Signature:

Date:

Acknowledgements

I wish to thank the following people who have provided much needed support over the last two years as I have learned a new way of making sense of information.

Professor Alan Pearson, my principal supervisor, who is the driving force behind my review, showing me the way through, in as few words as possible, when I seemed to be going nowhere.

Dr Christina Hagger, who at the beginning, gave me warm and caring support to keep me going at this very early stage.

Associate Professor John Field my associate supervisor, for listening.

Maureen Bell, Research Librarian at the University of Adelaide, for being interested enough to ring me at home in Tasmania when I couldn't get to see her in Adelaide.

The amazing University of Adelaide library staff who provided me with many of the papers that I could not access. Nothing seemed a bother for them.

Fellow student Cobie George for reading all of my review papers even though many of them distressed her.

Joanna Briggs Institute staff who were always helpful, especially Alexa and Vanessa.

All of my fellow students from the original group, and especially David who made me laugh.

Finally, my friend in Tasmania who had to do most of the work around the property because I no longer had any time

Table of Contents

Executive Summary	1
Background	1
Objectives.....	2
Inclusion criteria	2
Search strategy	3
Methodological quality	3
Data collection.....	3
Data synthesis.....	3
Results	4
Conclusions.....	5
Keywords.....	5
Introduction to the Review	6
Situating the review	6
Operational definitions.....	8
Survivor.....	8
Trauma	8
Cohort	9
Structure of the thesis	10
Background to the review	11
Review Design and Methods	21
Objectives.....	21
Inclusion criteria	21
Search strategy	22
Appraisal of the texts	25
Data collection.....	25
Data Synthesis	26
Conflicts of Interest.....	27

Results	27
Search Results	27
Findings	28
The First Synthesised Finding – <i>Contextual Understanding</i>	31
1.1 The Cohort Effect	34
1.2 Historical and Cultural Changes Over the Life Span	39
1.3 Life Events, Timing, Transitions, Risks	44
1.4 Linked or Interdependent Lives	58
1.5 Human Agency to Make Choices	67
1.6 Diverse and Interacting Life Course Trajectories	70
The Second Synthesised Finding <i>Acting on Understanding</i>	77
2.1 Overarching Safety	80
2.2 Health Professionals' Expertise and Values	91
2.3 Identification and Disclosure Issues	101
2.4 Principles of Therapeutic Management	112
2.5 Optimised Therapeutic Interventions	127
2.6 Research: Evidence to Guide Care	137
Discussion: Conclusions and Implications	142
Conclusions	142
Implications for practice	144
Implications for Research	151
Conflicts of Interest	152
APPENDICES	153
Appendix I - Relational tables	153
Appendix II - Search Strategy	173
Appendix III Search Results	180
Appendix IV – Texts Selected for Retrieval	181
Appendix V - Appraisal of Selected Texts	189
Appendix VI - Data Extraction from Included Texts	191
References	197

List of Tables, Figures and Diagrams

Figures

Figure 1. Overview of the Two Synthesised Findings	29
Figure 2. Flow Diagram of Study Selection	180
Figure 3. NOTARI Critical Appraisal Instrument	189
Figure 4. NOTARI Data Extraction Instrument	191

Tables

Table 1.1 The Cohort Effect	36-37
Table 1.2 Historical and Cultural Changes Over the Life Span	41-42
Table 1.3.1 Early in Life – Events, Timing, Transitions, Risk and Protection	46-47
Table 1.3.2 In Older Age – Events, Timing, Transitions, Risk and Protection	51-52
Table 1.3.3 During Physical/Cognitive Decline – Events, Timing, etc	55-56
Table 1.4 Linked or Interdependent Lives	61-64
Table 1.5 Human Agency to Make Choices	68
Table 1.6 Diverse and Interacting Life Course Trajectories	72-74
Table 2.1.1 Safety for the Older Adult Survivors	82-84
Table 2.1.2 Safety for the Health Professionals	88-89
Table 2.2.1 Health Professionals' Expertise and Knowledge	92-93
Table 2.2.2 Health Professionals' Values and Attitudes	97-99
Table 2.3.1 Identifying Older Adult Survivors	103-105
Table 2.3.2 Disclosure Issues for Older Adult Survivors	109-110
Table 2.4 Principles of Therapeutic Management	118-123
Table 2.5 Optimised Therapeutic Interventions	131-134
Table 2.6 Research: Evidence to Guide Care	139-140
NOTARI Table 1 NOTARI Summary Appraisal of Included Texts	189-190
NOTARI Table 2 NOTARI Summary of Included Papers	191-196

Relational Tables

Master Table 1. The Master Table of Texts	154-156
Relational Table 1.1 The Older Adult Survivors	157-158
Relational Table 1.2 The Abuse & Consequences	159-161
Relational Table 1.3 The Disclosure History	162-164
Relational Table 1.4 The Presentations & Problems	165-167
Relational Table 1.5 The Treatments & Therapies	168-170
Relational Table 1.6 The Outcomes of Interventions	171-172

NOTARI-View Diagrams

NOTARI-View Master Overview of the Synthesised Findings	30
NOTARI-View 1.1 – The Cohort Effect	38
NOTARI-View 1.2 - Historical and Cultural Changes	43
NOTARI-View 1.3.1 - Early in Life – Events, Timing, Transitions, Risk & Protection	48
NOTARI-View 1.3.2 - In Older Age – Events, Timing, Transitions, Risk & Protection	53
NOTARI-View 1.3.3 - During Physical/Cognitive Decline – Events, Timing, etc	57
NOTARI-View 1.4 - Linked or Interdependent Lives	65-66
NOTARI-View 1.5 - Human Agency to Make Choices	69
NOTARI-View 1.6 – Diverse Life Course trajectories	75-76
NOTARI-View 2.1.1 - Safety for the Older Adult Survivors	85
NOTARI-View 2.1.2 – Safety for the Health Professionals	90
NOTARI-View 2.2.1 – Health Professionals’ Expertise and Knowledge	94
NOTARI-View 2.2.2 – Health Professionals’ Values and Attitudes	100
NOTARI-View 2.3.1 – Identifying Older Adult Survivors	106-107
NOTARI-View 2.3.2 – Disclosure Issues	111
NOTARI-View 2.4 - Principles of Therapeutic Management	124-126
NOTARI-View 2.5 – Optimised Therapeutic Interventions	135-136
NOTARI-View 2.6 – Research	141

Logic Matrix Search Strategies

Logic Matrix 1 - Scopus	173-174
Logic Matrix 2 – PubMed Medline	175
Logic Matrix 3 – CINAHL	176
Logic Matrix 4 – PsycINFO PsycARTICLES	177
Logic Matrix 5 – Google Scholar and Other Generic	178
Logic Matrix 6 – Illumina	179

Executive Summary

Background

There is an extensive body of literature, of varying quality, on the effects and management of childhood sexual abuse for children, adolescents, young adults and to a lesser extent, middle aged adults. However, even though the older population is increasing rapidly, there has been little attention given to the long term effects of childhood sexual abuse in the older population. The reasons are complex and steeped in history, culture and entrenched attitudes.

Childhood sexual abuse in modern times is still predominantly a hidden problem, even in economically developed countries. The silence around this matter would have been more deep-rooted in the early decades of the twentieth century, when the aged persons of today were children, living in a culturally, economically, and legislatively different world.

Childhood sexual abuse survivors do not disclose their abuse readily and it is unlikely that unresolved trauma in older adults will present as the primary problem or as an identifiable syndrome; rather it is likely to have a disguised presentation with indicators such as depression, somatic disorders, self-harm, posttraumatic stress disorder (PTSD), substance abuse, 'challenging' behaviours, low self-esteem, or poor interpersonal relationships; to name just a few. The symptoms and problematic behaviours that can occur in older people need be professionally evaluated and managed, rather than dismissed as an inevitable part of ageing or as a result of dementia.

The ability to effectively identify, and treat, those older persons whose physical and or mental health is being adversely affected by their long ago childhood sexual abuse, are legitimate and urgent enterprises in light of the rapidly aging population, intensified by a paucity of evidence to do either well.

Health professionals also need to care for themselves, because dealing with older people with difficult problems or hearing horrific stories of abuse, can lead to 'burnout' and secondary trauma. Health professionals can also be survivors of childhood sexual abuse.

Objectives

The overall objective of this review was to inform practice, especially the identification and management, of those persons who have survived into old age, and who are now experiencing or eliciting problems related to the past trauma of their childhood sexual abuse. The review aimed to uncover themes and conclusions about the institutional, social, community, relationship and individual factors that might intensify or diminish the unresolved traumatic effects of childhood sexual abuse in the older person.

Inclusion criteria

Types of participants

The population of interest was all health professionals including but not limited to, psychiatrists, psychologists, registered nurses, medical doctors, social workers and other clinicians or therapists who had professional experience with older adults who were sexually abused as children. Older adults were defined as those aged 60 years and over.

Types of phenomena of interest

Of interest were the experiences and expert opinions of health professionals who had professional experience with older adults who were sexually abused as children.

Types of papers

The textual evidence considered included expert opinions, comments, assumptions or assertions, discussion papers, position papers and case studies that appeared in journals, magazines, books, monographs, reports and government publications including government web based publications. Unpublished papers such as dissertations were also considered.

Types of outcomes

Not Applicable

Search strategy

The search strategy aimed to find both published and unpublished papers. A three step search strategy was utilised for this review. An initial limited search of MEDLINE, CINAHL and PsycINFO was undertaken followed by analysis of the text words contained in the title and abstract, and of all the index terms used to describe the article. A second search using all identified keywords and index terms was then undertaken across all included databases. Thirdly, the reference list and citations of all identified reports and articles was searched for additional papers. This included manual searches of relevant journals, books, opinion papers, conference proceedings and dissertations. Fifty nine texts were retrieved for full text assessment for eligibility, from which the final 26 texts and papers were selected for critical appraisal prior to inclusion in the review.

Methodological quality

The 26 texts and papers selected for retrieval were assessed by two independent reviewers for authenticity prior to inclusion in the review using *standardised critical appraisal instruments* from the Joanna Briggs Institute Narrative, Opinion and Text Assessment and Review Instrument (JBI-NOTARI). All 26 texts were included in the review.

Data collection

Textual data was extracted from texts and papers included in the review using the *standardised data extraction tool* from JBI-NOTARI. This involved the reading and re-reading of the texts closely to identify the key themes and metaphors that then made up the findings and conclusions. 325 Findings were extracted from the 26 texts.

Data synthesis

Textual papers were pooled using the Narrative, Opinion and Text Assessment and Review Instrument (JBI-NOTARI). The 325 findings were aggregated into 12 categories on the basis of similarity of meaning and the resultant categories were then grouped into the 2 synthesised findings.

Results

The 26 texts that met the inclusion criteria for this exploratory narrative systematic review of text and opinion are summarised in Master Table 1. Master Table of Texts, in Appendix I. The texts are from 16 different journals and 7 book chapters in 5 books, published between 1986 and 2010.

The texts were authored by health professionals and academics in the fields of psychology, social work, gerontology, psychiatry, old age psychiatry, nursing, psychiatric nursing, counselling, neurology, neuropsychology and sociology.

The texts had their origins in the USA (18), the UK (5) and one each from Canada, Sweden and the Netherlands.

From these 26 texts, 325 findings were interpretatively extracted on the experiences, and opinions surrounding those experiences, of health professionals with 38 older adults aged from 60 to 90 years (34 females and four males).

Extraction, interpretative analysis and aggregation of the findings, from the experiences of health professionals with older adult survivors, has resulted in two inter-related synthesised findings based on - *Understanding followed by Action*. These Synthesised Findings are:

- Health professionals, at all levels, who are involved in the care of older adults, need to understand their clients in context; how the problems they currently experience may be related to sexual abuse in childhood and the dynamic consequences of that abuse across the older person's entire life course.
- Health professionals should use their contextual understanding of their older clients' lives; which may include sexual abuse during childhood, to guide care within an optimised professional therapeutic alliance based on safety for both the older adult and the health professionals.

Conclusions

This systematic review of text and opinion uncovered a rich vein of information on the experiences of health professionals with older adults sexually abused as children; and while the information may be particular to the cases described, it draws on a wide range of professional opinion. With a lack of empirical data of any quality to guide practice, this textual information can be used, thoughtfully, in clinical practice.

The stories of these 38 older adult survivors demonstrate that they can be helped, and that they can change at any age (Relational Table 1.6 The Outcomes of Interventions, in Appendix I). Even if resolution is not possible, the older person's quality of life can be improved in many cases. This highlights the importance of health professionals acting to help; even the very old, the dementing and the dying, to find some release from their distress, which may have its roots in childhood sexual abuse many decades earlier.

The first synthesised finding highlights the need for health professionals, at all levels, who are involved in the care of older adults, to understand how problems currently experienced by their older clients can be related to sexual abuse in childhood and the dynamic consequences of the abuse across the older person's entire life course. As an example, this cohort of older adult survivors may express their emotional distress in somatic rather than psychological ways because of the values that they have grown up with.

The second synthesised finding asserts that health professionals should use their understanding of the effects of childhood sexual abuse across the life course, to assist in the identification of older clients who may be survivors of childhood sexual abuse. Health professionals with this understanding, together with appropriate values and attitudes, should then act to effectively guide care. It may be particularly important for health professionals to enquire about the abuse history of older clients presenting with chronic affect disorders or substance abuse.

Keywords

"older adult survivor of childhood sexual abuse", "older adult survivor", "older male survivor", "older female survivor", "older women survivors"

Introduction to the Review

Situating the review

This narrative review examines the extant literature on the experiences of health professionals with older adults affected by the trauma of their childhood sexual abuse. I became interested in this topic as a result of my work as a registered nurse in a small residential aged care facility because of one special resident, who I will call Helen.

Helen's story provides the sense-making behind this review. I met Helen before she became a resident, when she was a carer for her husband. Soon after admission to the facility it became obvious that Helen was more cognitively impaired than anyone realised. Over the next few years, as her cognitive function deteriorated, so did her behaviour. Helen often cried and wanted to go home to her mother — then she started to talk about her father, who “did things” to her. Many different activities; music, a picture, a television story, would send her back to her childhood fears.

Afternoons were the worst; when we tried to get Helen ready for bed she would become resistive. There were only two of us on afternoon shift, myself and a care assistant, and it was always busy. The care assistant would often look at me and say “you have to do something”. That “something” was usually PRN oxazepam, and it did solve our problem as she fell asleep soon after and we could get on with our work. And I thought no more of it.

Helen was assessed by the geriatric service and started on a small dose of the atypical antipsychotic, risperidone. Within days she developed a serotonin syndrome; a very high temperature, and nearly died. Antidepressant medications were also tried unsuccessfully.

I was accepted into the Master of Clinical Sciences programme with the Joanna Briggs Institute, at the University of Adelaide and had to choose a topic for my review. I thought of Helen, and how her earlier abuse was contributing to such unhappiness for her in her last years, how it affected her family, and how distressing it was for the staff caring for her.

While there is extensive literature about all aspects of childhood sexual abuse for children, adolescents, younger and middle aged adults, preliminary exploration for this systematic review, strongly suggested that there had been little empirical study considering any aspect

related to older adults. Having read systematic reviews where the number and or quality of the studies had led the reviewer to conclude that no analysis was possible and therefore a narrative summary was more suitable, I considered that it would be appropriate and legitimate to consider a systematic review of text and opinion from the outset.

The Joanna Briggs Institute assert that *“Whilst expert opinion is rightly claimed to not be a product of “good” science, it is empirically derived and mediated through the cognitive processes of practitioners who have typically been trained in scientific method. This is not to say that the superior quality of evidence derived from rigorous research is to be denied; rather, that in its absence, it is not appropriate to discount expert opinion as non-evidence.”* (SUMARI User Guide, page 102)¹

As the narrative review progressed and I came to know the extant literature, I realised that I could no longer take the easy, oxazepam way out in my clinical work. When giving out the night medications I often sat and talked to Helen or watched ‘Spicks and Specks’; a music based game show, with her – we would look at each other and both laugh, because neither of us knew the answers – by this time Helen couldn’t even put a simple sentence together. I occasionally still had to give Helen ‘PRN’, but only when I realised her psychic pain was so great that she needed relief, not because I wanted to solve my nursing problem.

However, eventually oxazepam won, and Helen received a regular order. Within a week she was putting her fork in her ear and could no longer feed herself properly. Some staff considered it successful that Helen was no longer “difficult”. I left soon after. Earlier this year I attended Helen’s funeral, and it was as she would have wanted, simple and happy.

I have a degree in applied statistics, and have poured scorn on non-quantitative studies over the years, but no data analysis or tests of significance, could ever hope to provide the understanding and insight that I have gained from the process of synthesising narrative information over the last two years. I now have no doubt that sense-making can emerge from the synthesis of narrative text and opinion, and in concert with evidence gained from rigorous research, can be used to guide care.

Operational definitions

Survivor

The term 'survivor' in this review, is used simply as a convenient shorthand term for a person who was sexually abused in childhood, and does not aim to imply; a positive outcome, that all 'survivors' find the term empowering, or that being a survivor of childhood sexual abuse is enough.

When referring to a person who has suffered trauma; including childhood sexual abuse, the term 'survivor' is often used. Munro and Randall assert that: *"Of all the different metaphors used to emphasize the importance of safety and control, probably the most significant is that of 'survivor'. The survivor metaphor is quite different from the label of a passive victim or sufferer of a condition. The idea of a survivor is a positive affirmation of the individual's own power to endure"*.²

However, the survivor metaphor should not be seen simply as a positive affirmation of endurance. Hunter in her 2009 paper titled 'Beyond Surviving: Gender Differences in Response to Early Sexual Experiences with Adults' concludes that: *"both victim and survivor discourses are potentially limiting and possibly even stigmatizing"*. Hunter suggests that there is a gender difference, with women more likely to find victim and survivor discourses empowering, and men more likely to find them stigmatizing and unhelpful.³

The title of the Australian Women's Coalition, 2010 Consultation Report; 'Happy Healthy Women: Not Just Survivors' suggests that a being a survivor, or enduring, is not enough. Survivors also have a right to long-term healing opportunities and the right to be happy and healthy.⁴ The Coalition does not apply an age limit to these basic rights. Additionally, men should also have these same rights.

Trauma

In her ground-breaking book; 'Trauma and Recovery', Judith Herman writes that: *"Traumatic reactions occur when action is of no avail. When neither resistance nor escape is possible, the human system of self-defense becomes overwhelmed and disorganized. Each component of the ordinary response to danger, having lost its utility, tends to persist in an altered and exaggerated state long after the actual danger is over. Traumatic events*

*produce profound and lasting changes in physiological arousal, emotion, cognition, and memory.”*⁵

According to Hyer in ‘The Effects of Trauma: Dynamics and Treatment of PTSD in the Elderly’, trauma work has become one of the principal constructs of modern psychiatry. Hyer asserts that; *“Trauma is everywhere”*. However, Hyer also asserts that understanding trauma at older ages is just beginning.⁶

Morrison and colleagues propose some limitations to the trauma paradigm, including the possibility that some symptoms *“...rather than being viewed as problems to be treated, need to be viewed in a more positive light – as “coping mechanisms” an individual has adopted for protection and other purposes.”* They also suggest that by focusing on individuals and their symptoms the wider social context of trauma may be sidelined.⁷

Cohort

Bob Knight in his book, ‘Psychotherapy With Older Adults’, writes that cohort differences can be explained by; *“...membership in a birth-year-defined group that is socialized into certain abilities, beliefs, attitudes, and personality dimensions that will stay stable as the group ages and that distinguishes that cohort from those born earlier and later”*.⁸

Knight suggests that: *“Perhaps one of the most undeveloped aspects of understanding psychotherapy with older adults – comprehending psychologically significant cohort effects – is not essentially different in quality or difficulty from learning to work with clients from other cultures or from the other gender”*.⁸

Based on the evidence of Schaie, Knight also proposes that cohort differences are less pronounced for those born in the latter half of the 20th century, so that adaptations in psychotherapy may become less necessary when the cohorts born after the Baby Boomers (a large cohort born after the Second World War – 1945 to 1965) become older adults.⁸

Structure of the thesis

The basic structure of the thesis arises from the Joanna Briggs Institute's methodology for the systematic review of narrative evidence, which closely follows the PRISMA Statement for Reporting Systematic Reviews, as described by Liberati et al.⁹

The overview of the Executive Summary is followed by the first section of the thesis; the Introduction to the Review, which situates the review, explaining why I thought it important to choose this particular topic. The Introduction also provides basic operational definitions and discusses the background to the subject of the review in detail.

Having set the scene, the second section of the review; Review Design and Methods, then outlines the methodological structure of the review process. This section provides the objectives, inclusion criteria and search strategies that led to the collection of data, then outlines how this information was appraised and finally synthesised.

The Results section is the heart of the thesis providing a detailed examination of the synthesised findings. This section has two major sub-sections based on the two synthesised findings and the categories from which they have been constructed. This section also contains detailed tables and NOTARI-View diagrams that present the raw data and basic interpretative findings from the texts included in the review.

The final section contains the Discussion, Conclusions and Implications for Practice and Research which look forward to provide some direction for practice and research.

The Appendices contain extensive relational tables that summarise many of the aspects of the information retrieved from the review and that should be used as an adjunct to the Results section.

Background to the review

Overview

There is an extensive body of literature, of varying quality, on the effects and management of childhood sexual abuse for children, adolescents, young adults and to lesser extent middle aged adults. However, even though the older population is increasing rapidly, there has been little attention given to the long term effects of childhood sexual abuse in the older population. The reasons are complex and steeped in history, culture and entrenched attitudes.

Childhood sexual abuse in modern times is still predominantly a hidden problem, even in economically developed countries.¹⁰⁻¹² The silence around this matter would have been more deep-rooted in the early decades of the twentieth century, when the aged persons of today were children, living in a culturally, economically and legislatively different world.

In a recent large Australian survey of persons aged 60 years and over, Draper and colleagues found that *“participants who had experienced either childhood sexual or physical abuse had a greater risk of poor physical and mental health”*.¹³ Havig in a review of the literature argues that these health effects are wide-ranging and long term.¹²

If the impact of childhood sexual abuse on the older population in the developed world receives little attention, then in the developing world where life expectancy is still very low; (for instance Nigeria with a life expectancy in 2008 of 48 years)¹⁴ it is understandable that the focus is elsewhere. However, while life expectancy may be low, the overall numbers can still be very large, for instance in Nigeria the number of people age 60 years and over is predicted to increase from 7.5 million in 2009 to nearly 28 million in 2050.¹⁵

There is emerging interest in the psychopathology of old age in developing countries as shown by a recent study on the epidemiology of major depressive disorders in elderly Nigerians by Gureje and Afolabi.¹⁶ This survey concluded that *“major depressive disorder is common in elderly Nigerians and its occurrence is related to urbanisation”* and that *“only a few sufferers have ever received treatment”*.¹⁶ Another recent Nigerian study by Oladeji and colleagues; on adverse childhood experiences as risk factors for psychiatric disorders,

concluded that adverse childhood experiences did have *“significant mental health consequences in adulthood”*.¹⁷

An insight into the reasons for the lack of attention given to the late effects of childhood sexual abuse in older persons can be gained from the discussion by Gaitz¹⁸ in his 1974 paper, about the barriers to psychiatric service delivery to the elderly. Although an older paper, it still has modern relevance. Gaitz argues that negative attitudes of service providers to the elderly results in a *“therapeutic nihilism”* where the problems of the elderly are not able to be solved and where decline is inevitable.¹⁸ Gaitz has a more positive view where *“impairment cannot always be equated with disability and that illnesses in the aged are often reversible, and that psychological symptomatology manifested by old people is not inevitably and inherently related to organic brain conditions for which there is no treatment”*.¹⁸ This last assertion is particularly important because it places the symptoms and problematic behaviours that can occur in older people in a context where they can be professionally evaluated and managed, rather than dismissed as an inevitable part of ageing or a result of dementia. Cuijpers and colleagues in a meta-analysis of randomised controlled trials of psychological treatment for late-life depression, concluded that *“there is no doubt that psychological treatments are effective in older adults with depression”*.¹⁹ They further assert that *“the effects of psychological treatments are comparable to the effects of pharmacological treatments”*¹⁹ for some types of depression.

As the person who suffered sexual abuse as a child matures into old age, it follows that they will incur losses that may make them psychologically vulnerable to the emergence of past trauma. They may lose their partner, their friends, their health, their mental capacity, and their independence. They may even lose their home and their everyday rituals and have to make a major life change by moving in with their children or moving to a residential aged care facility.

Such institutions may unwittingly reproduce the *“dynamics of previous victimisation”*,²⁰ according to Peters and Kaye, who illustrate this assertion with the following example; *“...even if staff perceive their act to be something as benign as gentle guidance applied to the elbow, for an older abuse survivor, such guidance may re-evoked intense somatic memories of having her hand or head “guided” in the direction of the abuser’s genitalia”*.²⁰

Peters and Kaye also discuss the loss of choice inherent in the hierarchical nature of institutions; *“when choice is removed, old feelings, memories, and responses characteristic of the response to child sexual abuse may re-emerge”*.²⁰

Older adult survivors with a dementing illness may have complex presentations manifest in 'challenging behaviours', for instance aggressive behaviour towards carers during bathing. Peters and Kaye argue that if staff in aged care facilities attempt to manage these challenging behaviours by maintaining a *“distant behaviourally orientated professional stance while the survivor endures the horror of the re-experienced abuse”*²⁰ they may unwittingly recreate the childhood environment where the person was originally abused and neglected and thus worsen the older persons suffering and exacerbate the behaviour.

Childhood sexual abuse survivors do not disclose their abuse readily²¹ and it is unlikely that unresolved trauma in older adults will present as the primary problem or as an identifiable syndrome;²² rather it is likely to have a disguised presentation with indicators such as depression, somatic disorders, self-harm, post traumatic stress disorder (PTSD), substance abuse, low self-esteem, or poor interpersonal relationships; to name just a few. Such presentations might increase the level of suspicion of past childhood sexual abuse by the experienced health professional. While this is probably true for both male and female survivors, Holmes and colleagues when discussing the relative failure of clinicians to consider childhood sexual abuse when referring male adults for therapy, argue that the *“failure of early identification may be because male victims of childhood sexual abuse are highly likely to come with a disguised presentation, such as anxiety, suicidality, hostility, rage or hypermasculine behaviour e.g. aggression”*.²² When discussing mental health counselling for adult women survivors of childhood sexual abuse using a wellness approach (this approach focuses on the persons strengths and de-pathologises the abuse), Hodges and Myers state that the *“plethora and severity of symptoms and symptom clusters require multiple and broad-based approaches to mental health counselling”*.²³ This concept of multiple and broad-based treatment strategies; ideally provided by a range of experienced health care professionals working together as a team, is possibly the foundation for the effective management of childhood sexual abuse trauma in adult life.

Old age is a dynamic life stage that many childhood sexual abuse survivors, with support, and healthy coping strategies, developed over a long life, will manage to negotiate successfully. Others will not be so lucky, and the trauma of childhood sexual abuse may re-emerge in ways they, their family and health professionals may never recognise or manage empathetically.

The children in context

The survivors of the cohort of children who were sexually abused in the period between the two world wars (1918 to 1939) are now among the oldest old i.e. the 80 to 85 years plus. These people were young children in a tumultuous world with little safety outside the family.

Soon after World War I the western world again moved towards a world war in Europe and the Pacific. People were also on the move, with mass migrations out of southern and eastern Europe to the 'new worlds'. The Australian Bureau of Statistics Census of Population and Housing shows that in 2006 there were approximately 123,000 people aged 75 years and over (9.7% of this age group) living in Australia, who were born in Southern and Eastern Europe.²⁴ The immigrants may have arrived as children or later as adults, but nonetheless some of them will have been sexually abused as children. Some will have dementia and have to be cared for in a different culture to the one they lived in as a child, by carers who speak a different language. Kong and colleagues in a qualitative study of Korean immigrant caregivers of non-english-speaking (NES) older relatives with dementia, cite several studies suggesting that *"as dementia progresses, NES older people with dementia lose their more recently gained communication skills in English, thus limiting communication"*.²⁵ They may also revert back to earlier cultural practices that may be misinterpreted as a 'challenging behaviour' by carers; for instance in this Korean example, a return to sleeping on the floor.²⁵

The sexual abuse

Contemporary definition

There is continuing debate about a contemporary definition of childhood sexual abuse, however the World Health Organisation (WHO) in 2002 defined childhood sexual abuse as *"the involvement of a child in sexual activity that he or she does not fully comprehend, is*

unable to give informed consent to, or for which the child is not developmentally prepared, or else that violates the laws or social taboos of society. Children can be sexually abused by both adults and other children who are by virtue of their age or stage of development in a position of responsibility, trust or power over the victim".²⁶

The use of children sexually by adults has probably occurred in most societies since the beginning of civilisation. Rush in her 1980 book "Best Kept Secret – Sexual Abuse of Children", claims that these *"historical patterns dating from before biblical times have been instrumental in sanctioning and perpetuating sex between children and adults"* across all *"social, economic and racial lines"*.²⁷ The recognition of all forms of child abuse as a crime is a relatively recent historical achievement, even in developed countries. WHO asserts, that there is now almost *"virtual unanimity"* ²⁶ that the abuse of children, which is harsh or sexual in nature, is a global problem.

Despite the current progress towards the recognition of childhood sexual abuse as a crime, it is still grossly underreported.^{20, 28} Neame and Heenan found in several modern studies that some of the reasons that children did not disclose their sexual abuse were *"fear of family breakdown, a sense of ongoing responsibility for the safety of other children or family members, and fears for their own personal safety"*.²⁸ Easta's 1992 Australian national survey of survivors of sexual abuse, found that 52.6% of males and 37% of females had never told anyone that they had been sexually abused.²¹

Prevalence

There is an extensive body of contemporary literature on the prevalence of childhood sexual abuse, mainly produced in the more developed countries. Most commentators agree that the rates are probably underestimations.^{11, 29} WHO in 2002; using studies from all over the world, stated that *"approximately 20% of women and 5% to 10% of men report having been sexually abused as children"*.²⁶

However, historical childhood sexual abuse prevalence rates are even more difficult to determine. Finkelhor reports on an innovative approach where the rates of childhood sexual abuse for different age groups within the same study are compared. The results show lower rates for the oldest group.¹¹ Finkelhor suggests one explanation may be an *"artifact of*

*disclosure*¹¹ where the very old may not remember the long ago abuse or are too private to disclose it. Draper and colleagues also found that the participants aged 80 and over had the lowest reported rate of childhood sexual abuse (2.6% compared to 9.5% for the 60 to 69 year age group).¹³ The authors suggest that persons who have been abused; physically or sexually, as children are “*at greater risk of early death*”¹³ because of the plethora of physical and mental problems that are more prevalent in this group as they age. Another reason could be that people with dementia are less likely to be represented in these surveys, because cognitive impairment can be an exclusion criteria and the prevalence of dementia increases with age. WHO estimates of dementia prevalence worldwide clearly demonstrates the large relative increases in dementia prevalence from the age of 80 years.³⁰ In Sub-Saharan Africa the prevalence of dementia increases from 3.8% in the 75 to 79 year age group, to 14.9% in the 85 years and over group.³⁰ In North America the corresponding rates are 6.5% to 30.1%.³⁰

Perpetrators

Finkelhor reports that 90% of the perpetrators are male, and that 70% to 90% are known to the child.¹¹ He further reports that, one-third to one-half of the perpetrators against girls, and 10% to 20% of the perpetrators against boys, are family members.¹¹ Non-biological male family members, for example, step-fathers, are disproportionately represented, according to Russell [17% of girls living with step-fathers compared to 2.3% living with their biological father].³¹ Perpetrators also include non family members who the child could expect to trust; for instance priests (clerical abuse), teachers, health professionals and care providers in institutions.

Age at onset and length of abuse

Based on a review of the extant literature, Peters and Kaye state that the onset of the sexual abuse of children is “*reported with great consistency as occurring most frequently between 7 and 10 years*” of age.²⁰ Faller states that the average length of abuse is 3.6 years if the biological father is the perpetrator, 2.4 years for de facto or step fathers and 1.9 years for non-custodial fathers.³²

Adverse effects

Sexual abuse occurs at an important time in the psychosexual development of the child, and the research literature generally asserts that it can have lifelong adverse effects, ranging from relationship difficulties to physical and mental health issues and suicide.^{12, 13} Mullen and colleagues hypothesise that the *“fundamental damage inflicted by CSA is to the child’s developing capacities for trust, intimacy, agency and sexuality”*³³ and that later mental health problems arise from these developmental wounds.³³

Lamont says that *“one adverse outcome may lead to another”*;³⁴ substance abuse may lead to risky sexual behaviour, and both may result in physical health problems. The abused child also has an increased risk of re-victimisation throughout their life. Mouzos and Makkai say that the risk of suffering sexual violence doubles for women who were sexually abused as a child.³⁵

Fergus and Keel found correlations in the literature between childhood sexual abuse and adverse outcomes like *“depression, anxiety disorders, antisocial behaviour, substance abuse, eating disorders, suicidal behaviour, and post-traumatic stress disorder”*.¹⁰ Klafter says that child abuse, including sexual trauma, is a significant factor in the complex mix of psychiatric disorders including schizophrenia, dissociative disorders and borderline personality disorder.²⁹ Male and female victims of female perpetrators, have similar problems, but additionally; according to Denov, they suffer unique long term effects such as *“confusion surrounding their self-concept and identity, and intense rage that is often directed at women, in fantasy and in reality”*.³⁶

Cattell discussing suicidality in the general elderly population, states that, *“suicide rates in most industrialised nations increase with age, the highest rates of all occurring in elderly men”*.³⁷ Cattell says that elderly men are particularly vulnerable following bereavement.³⁷ Draper and colleagues found that 8.4% of survey participants aged 60 years and over who had been sexually abused as a child, admitted to a suicide attempt during their lifetime, compared to only 1.9% for those not sexually abused.¹³ Cattell cautions that *“attempted suicide should always be taken seriously in the elderly and is most likely to represent a failed bid”*.³⁷ While the majority of the elderly do not attempt suicide; when they do, they have a high rate of completion.³⁷ The contribution of childhood sexual abuse to this

complex mix of loss, depression, physical decline and past suicide attempts is unknown but worthy of investigation.

Klafter says that the long term consequences of childhood sexual abuse are determined by many factors, including: the age of the child when abused; the type, severity and duration of the abuse; the child's relationship to the abuser; concomitant physical abuse or neglect; supportive close relationships; appropriate, early mental health treatment and environmental, genetic as well as constitutional factors.²⁹

Gordon emphasises that it should not be assumed that the person is constantly vulnerable.³⁸ Those who have had caring support and treatment are better able to deal with the trauma, if and when it re-emerges.³⁸ The ability to effectively identify and treat those older persons whose physical and or mental health is being adversely affected by their long ago childhood sexual abuse, is a legitimate and urgent enterprise in light of the rapidly aging population.

The health professionals

Most health professionals come into contact with older adult survivors of childhood sexual abuse; medical practitioners, nurses, psychologists, social workers, occupational therapists, physiotherapists and pharmacists to name just a few. Schachter and colleagues in the "Handbook on Sensitive Practice for Health Care Practitioners: lessons from Adult Survivors of Childhood Sexual Abuse" assert that this is so because of the prevalence of childhood sexual abuse, and the increased risk that survivors have for a wide variety of health problems.³⁹ Schachter and colleagues say that *"survivors are health care consumers of every age who seek all types of health services"*.³⁹

Health professionals may be treating older adult survivors for depression, substance abuse, self-harm, suicidality, eating disorders, multiple somatic complaints, anger management, relationship problems and many other more mundane problems such as dental care or physiotherapy. Health professionals will be using pharmacotherapy, psychotherapy, diversional therapy, art therapy, music therapy, reminiscence and life review therapies and more. Health professionals will be caring for the elderly survivors in residential aged care facilities, psychiatric institutions, prisons, palliative care wards, emergency departments, in

the elderly persons own home. Health professionals will often not know that the people they are caring for were sexually abused as children, more than half a century ago.

Schachter and colleagues propose a framework of “*sensitive practice*”³⁹ that “*builds on core competencies to help health care practitioners be more understanding of and responsive to the specific needs of adult survivors of violence and abuse*”.³⁹ The authors also highlight the different perspectives that survivors of childhood sexual abuse may have of their interaction with the caring professions. Examinations and procedures that may seem innocuous or routine can be distressing to them “*because they may be reminiscent of the original trauma*”.³⁹ While health professionals may assure their clients that they are safe, Schachter and colleagues say that this is not enough, because perpetrators frequently assured them that they were safe, even as they abused them.³⁹

One of the main challenges for health professionals is the management of disclosure of the sexual abuse by the survivor. Schachter and colleagues discuss a range of disclosure patterns, from spontaneous disclosure, to survivors who choose not to disclose at all.³⁹ They also provide useful guidelines about how to react to disclosure and how not to react; for example, validation of the survivor’s experience is essential but minimizing the abuse, pitying or simplistic advice is unhelpful and potentially harmful.³⁹

Elderly survivors of childhood sexual abuse with a cognitive impairment may express their abuse behaviourally rather than verbally. When discussing the management of agitation and aggression associated with Alzheimer’s disease, Ballard and colleagues cite Cohen-Mansfield and colleagues who developed a ‘toolbox’ incorporating “*simple and practical psychological interventions, such as structured social interaction and meaningful activities, which can be individualised to the needs of a particular individual*”.⁴⁰

Health professionals may also have to modify psychological treatments for the elderly. As an example, a summary of the literature on the assessment and treatment of PTSD in older adults by Cook and O’Donnell notes that “*the initial presentation of PTSD is often less dramatic in older adults*”⁴¹ and that there are special concerns when working with older traumatised adults. These concerns include their physical health which may be compromised by direct trauma processing.⁴¹ Cook and O’Donnell say that “*before confronting traumatic material, it may be necessary for certain older survivors of severe and*

*prolonged abuse to first learn capacities for managing distress and coping effectively”.*⁴¹ Other treatment issues highlighted by the authors include the need to proceed more slowly, to include repetition, to present information in both verbal and visual modes, to only have a few clearly outlined goals and to have flexible scheduling, location and collaboration.⁴¹ They also add that *“because older adults often have concurrent physical and social problems, consultation and coordination with other health service providers are often essential”.*⁴¹

Finally, health care professionals need to care for themselves. Hodges and Myers say that *“listening to the stories of trauma survivors places the professional at risk of empathy fatigue and secondary trauma”.*²³

It is also important to note that health professionals may also be survivors of childhood sexual abuse.

Review Design and Methods

Objectives

The overall objective of this review was to inform practice, especially the identification and management, of those persons who have survived into old age, and who are now experiencing or eliciting problems related to the past trauma of their childhood sexual abuse. The review aimed to uncover themes and conclusions about the institutional, social, community, relationship and individual factors that might intensify or diminish the unresolved traumatic effects of childhood sexual abuse in the older person.

Inclusion criteria

Types of participants

This review considered publications that included Health Professionals, including but not limited to, psychiatrists, psychologists, registered nurses, medical doctors, social workers and other clinicians or therapists who have had professional experience with older adults who were sexually abused as children. Older adults were defined as those persons aged 60 years and over.

Types of phenomena of interest

This review considered publications that described the experiences and opinions of health professionals working with older adults affected by the trauma of childhood sexual abuse.

Types of papers

The textual evidence considered included expert opinions, comments, assumptions or assertions, discussion papers, position papers and case studies that appeared in journals, magazines, monographs, reports, books and book chapters and government publications including government web based publications. Unpublished papers such as dissertations were also included if they met the above inclusion criteria. Ultimately only papers containing case studies that met the inclusion criteria were included in the review, because of pragmatic considerations about the size of the review task.

Types of outcomes

Not Applicable to narrative meta-synthesis.

Search strategy

Only texts and papers in the English language published or downloaded before 31/12/2010 were included. The final search was completed on 30/6/2011. The search strategy aimed to find both published and unpublished papers. A three step search strategy was used for this review.

- An initial limited search of MEDLINE, CINAHL including Pre-CINAHL and PsycINFO was undertaken followed by analysis of the text words contained in the title and abstract, and of all the index terms used to describe the article.
- A second search using all identified keywords and index terms (see below) was then undertaken across all included databases: PubMed/Medline, CINAHL, PsycINFO and PsycARTICLES, Scopus, Google Scholar, Google Books, Illumina/Proquest, PILOTS (Published International Literature on Traumatic Stress).
- Thirdly, the reference list and citations of all identified reports and articles was searched for additional papers. This included manual searches of relevant journals, books, opinion papers, conference proceedings and dissertations. Identified texts were checked for further references considered pertinent to the review and this process repeated until no further relevant texts were found.

Although very idiosyncratic, a search using Google Books proved to be particularly productive. After identifying potential books I used TROVE, a search engine provided by the National Library of Australia, to identify libraries that carried the identified books. The best match proved to be Latrobe University, Bundoora, Victoria where I spent an afternoon manually inspecting the identified books as well as the Contents and Indices of any potentially relevant books in the same area. The latter produced no new discoveries. I could not find several of the books and so purchased them.

The search for unpublished studies initially included: International and Government affiliated websites with areas dedicated to childhood sexual abuse or aged care issues:

The National Guideline Clearinghouse (<http://www.guideline.gov/>)

The Australian Institute of Family Studies, www.aifs.gov.au

National Child Protection Clearinghouse

Australian Centre for the Study of Sexual Assault

Centre for Research on Families and Relationships; The University of Edinburgh

www.crfr.ac.uk

Ultimately 59 texts were retrieved for full text assessment for eligibility, from which the final 26 texts and papers were selected for critical appraisal prior to inclusion in the review (Figure 2. The Flow Diagram of Study Selection, in Appendix III).

Initial keywords used are listed below, however including the wildcards produced too many papers with no connection to the topic.

1. ((child* or girl\$ or boy\$ or adolescen*) and sex* and (abuse or assault)) or (incest or clerical abuse or institutional abuse)
2. adult or old* or old age or elder* or aged or ag\$ing or geriatric* or late life or aged, 65 years and over
3. dementia or alzheimer* or cognitive impairment or nursing home\$ or care home\$ or aged care facilit*
4. 1 and (2 or 3)

The final searches are presented in full in Appendix II - Search Strategy. The search used for PubMed/Medline appears below. All searches included the two main concepts, adapted for each database, that is:

- 1: Childhood Sexual Abuse and 2: Older Adults.

Text and Opinion was not introduced as a separate concept because preliminary test searches found it to be not useful, and to reduce the number of retrievals dramatically.

Logic Matrix Search Strategy 2 - Medline	
Database	PubMed Medline
<p>Concept 1: Childhood Sexual Abuse</p> <p>#1 child abuse, sexual[MeSH Terms] OR incest[MeSH Terms] OR pedophilia[MeSH Terms] OR adult survivors of child abuse[MeSH Terms]</p> <p>#2 "child sexual abuse"[tiab] OR "childhood sexual abuse"[tiab] OR "child sexual assault"[tiab] OR "childhood sexual assault"[tiab] OR "child sexual molestation"[tiab] OR incest*[tiab] OR Pedophil*[tiab] OR Paedophil*[tiab] OR Pederast*[tiab]</p> <p>#5 with Age Limits <i>(can be used instead of using Concept 2 – results almost the same)</i> (#1 OR #2) AND ("humans"[MeSH Terms] AND ("aged"[MeSH Terms] OR "aged, 80 and over"[MeSH Terms]) AND ("1"[PDAT] : "2010/12/31"[PDAT]))</p> <p>Concept 2: Older Adults</p> <p>#3 "aged"[MeSH Terms] OR "health services for the aged"[MeSH Terms] OR "homes for the aged"[MeSH Terms] OR "nursing homes"[MeSH Terms] OR "housing for the elderly"[MeSH Terms] OR "geriatric assessment"[MeSH Terms] OR "geriatric nursing"[MeSH Terms] OR "geriatric psychiatry"[MeSH Terms] OR "dementia"[MeSH Terms]</p> <p>#4 "Aged 65 and over"[tiab] OR "Aged 80 and over"[tiab] OR "Old age"[tiab] OR "Oldest old"[tiab] OR "Very old" [tiab] OR "Older women"[tiab] OR "Older men"[tiab] OR "Older adults"[tiab] OR "Older aged"[tiab] OR "Very old"[tiab] OR "Oldest old"[tiab] OR Elderly[tiab] OR "Frail elderly"[tiab] OR "Late life"[tiab] OR "Later life"[tiab] OR "Life review"[tiab] OR Senior\$[tiab] OR Elder\$[tiab] OR "Homes for the aged"[tiab] OR "Housing for the elderly"[tiab] OR "Old age homes"[tiab] OR "Nursing homes"[tiab] OR "Residential aged care facilities"[tiab] OR "Care homes"[tiab] OR "Skilled nursing facilities"[tiab] OR "Aging in place"[tiab] OR "Old age psychiatry"[tiab] OR "Old age psychiatrist"[tiab] OR Geriatric[tiab] OR "Geriatric nursing"[tiab] OR Geriatrician[tiab] OR Gerontolog*[tiab] OR Geropsycholog*[tiab] OR Psychogeriatric[tiab] OR Psychogeriatrician[tiab] OR Dementia[tiab] OR Alzheimer's[tiab] OR Alzheimers[tiab] OR "Corticobasal Degeneration"[tiab] OR Pseudodementia[tiab]</p> <p>#6 Limits – Human before 2011 (#3 OR #4) AND ("humans"[MeSH Terms] AND ("1"[PDAT] : "2010/12/31"[PDAT]))</p>	
<p>#7 Combining Concept 1: Childhood Sexual Abuse AND Concept 2: Older Adults with limits Human and before 2011</p> <p>((#1 OR #2) AND (#3 OR #4)) AND ("humans"[MeSH Terms] AND ("1"[PDAT] : "2010/12/31"[PDAT]))</p>	

Appraisal of the texts

In the Joanna Briggs Institute Reviewers' Manual (p120),⁴² Pearson asserts that: *"The focus on limiting bias to establish validity in the appraisal of quantitative studies is not possible when dealing with text and opinion. In appraisal of text, the opinions being raised are vetted, the credibility of the source investigated, the motives for the opinion examined and the global context in terms of alternate or complementary views are considered. Validity in this context therefore relates to what is being said, the source and its credibility and logic; and consideration of the overt and covert motives at play".*⁴²

Prior to inclusion in the review, the texts and papers that met the inclusion criteria were assessed by two independent reviewers for credibility, logic and motive, as asserted above, using *standardised critical appraisal instruments* from the Joanna Briggs Institute Narrative, Opinion and Text Assessment and Review Instrument (JBI-NOTARI) (Figure 3. NOTARI Critical Appraisal Instrument, in Appendix V). Any disagreements that arose between the reviewers were to be resolved through discussion, or with a third reviewer. However, no major disagreements that could not be resolved between the two reviewers occurred, and all 26 papers and texts were included in the systematic review.

Data collection

Data was extracted from the texts included in the review using the *standardised data extraction tool* from JBI-NOTARI (Figure 4. NOTARI Data Extraction Instrument, in Appendix VI). The data extracted included specific details about the phenomena of interest, populations, and themes and conclusions of significance to the review question and specific objectives.

"The JBI-NOTARI approach to reviewing text derived from sources other than research is a simplified adaptation of content and modified discourse analytical procedures ...The features of content analysis that JBI-NOTARI draws on include the need to read and re-read the text to identify the meaning of the content and the formation of statements that accurately describe the content. The features of discourse analysis that JBI-NOTARI draws on are the steps pursued to identify the degree to which the text being reviewed has "authority" in-so-far as its purpose and its focus on serving the best interests of health care recipients." (JBI-SUMARI, p101)¹

As described in the above excerpt from JBI-SUMARI, the 26 papers included in this narrative systematic review were read and re-read many times over months, to identify the findings; that is the metaphors, themes and conclusions. These findings all had meaning that was aimed to best serve older adult survivors of childhood sexual abuse and the health professionals who were caring, or might come to care, for them. A summary of the main finding/conclusion for each text is presented in NOTARI Table 2 in Appendix VI. Throughout the Results Section, the individual findings and the illustration for each from the texts, are presented in Tables related to each Category.

Data Synthesis

Textual data was pooled using JBI-NOTARI. This involved the aggregation or synthesis of the 325 findings; the themes and conclusions, to generate a set of statements that represented that aggregation, by assembling and categorising the findings on the basis of similarity in meaning. As synthesis progressed and the Categories emerged out of the aggregation of the findings based on similarity in meaning, two related but separate frameworks evolved that led into the final meta-synthesis.

The first framework was based on an existing perspective; the Life Course Perspective, into which many of the findings relating to the older adult survivors' life journeys, seemed to naturally fit. This resulted in 6 Categories aggregated from 131 of the findings.

The second framework evolved out of the 194 findings relating to health professionals' interactions with older adult survivors, and the Categories were constructed, with some reference to the extant literature. This aggregation resulted in 6 Categories.

While existing theories and literature were used in the final construction of the Categories to give them added contextual coherence, this structure was never predetermined; it emerged out of the basic findings. I had never heard of the Life Course Perspective, until I was well into the synthesis, and realised that one half of the emergent findings were well suited to interpretation through the lens of the Life Course Perspective.

Meta-synthesis resulted in a single comprehensive set of 2 Synthesised Findings that can be used as a basis for evidence-based practice.

Conflicts of Interest

None identified.

Results

Search Results

A total of 59 papers and texts, which included books and book chapters, were identified from the main search strategy as outlined in Figure 2. The Flow Diagram of Study Selection, in Appendix III. Of these, 33 were excluded because they did not meet the inclusion criteria, resulting in 26 texts being accepted for critical appraisal. All of these 26 texts passed the appraisal process and were included in the systematic review.

The 26 papers and texts that met the inclusion criteria for this exploratory systematic review of narrative text and opinion are summarised in the Master Table 1 The Master Table of Texts, in Appendix I, and NOTARI Table 2 Summary of Included Texts, in Appendix VI. The texts represent papers from 16 different journals and 7 book chapters from 5 books, published between 1986 and 2010 inclusive. The texts had their origins in the USA (18), the UK (5) and one each from Canada, Sweden and the Netherlands. The texts were authored by health professionals and academics in the fields of psychology, social work, gerontology, psychiatry, old age psychiatry, nursing, psychiatric nursing, counselling, neurology, neuropsychology and sociology. The 26 texts included themes and conclusions on the experiences, and opinions surrounding those experiences, of these health professionals with 38 older adult survivors of childhood sexual abuse, aged from 60 to 90 years. The older adult survivors described were overwhelmingly female (34 females and four males).

Texts ranged from simple case histories with minimal findings such as those by Benbow and Jagus,⁴³ Breitner and Anderson,⁴⁴ and Fakhoury and colleagues,⁴⁵ to papers and book chapters with extensive analysis and discussion that contributed many of the findings, including those by Allers and colleagues,⁴⁶ Colorusso,⁴⁷ Gagnon and Hersen,⁴⁸ Gallo-Silver and Weiner,⁴⁹ McInnes-Dittrich,⁵⁰ Osgood and Manetta,⁵¹ and Sutton.⁵² While the contributions of the 'simpler' texts may have been overwhelmed in the synthesis by the more 'complex' texts, they still provided valuable insights; for instance the older female

survivor, discussed by Benbow and Jagus, who suffered from complex grief after the death of her husband because her sexual problems, arising from her childhood sexual abuse, had never been addressed in over seven decades.⁴³

While most were discussion texts with illustrative case histories, often they also contained cases that did not fit the inclusion criteria, either because they were younger than 60 years or because they were not survivors of childhood sexual abuse. However, every attempt has been made to only include findings from those sections relating to the older adults sexually abused as children.

Diagrams providing a visual overview of the findings that make up each Category or Sub-Category within each Synthesis (adapted from the NOTARI-View diagrams output from the NOTARI Module of the Joanna Briggs Institute Comprehensive Review Management System CReMS software), and more detailed tables of these findings with illustrations from the text, are included at the end of each of the relevant results sections.

Findings

Sandelowski and Barroso in their typology of qualitative findings, note that because of “... *greater variation in styles of reporting qualitative research, even finding the findings in these studies can be more difficult than in quantitative research reports where a harder line is typically drawn between results and discussion*”.⁵³ The task of “*finding the findings*” in these 26 disparate and heterogeneous narratives of text and opinion was even more difficult, with no comparative underlying structure to ensure that similar data could be extracted, although many similar themes did emerge. However, in an area of aged care that has received almost no empirical or experiential study, these texts provided a surprisingly rich vein of information, albeit particular and subjective, that is complex and illuminating.

Meta-synthesis of the 26 texts included in the review generated 2 Synthesised Findings. These 2 Synthesised Findings were derived from 325 findings based on the themes and conclusions that were identified in the texts and that were subsequently aggregated into 12 Major Categories; six in each Synthesised Finding (see Figure 1. and the Notari-View Master following). The main finding; theme or conclusion for each of the 26 texts is listed in NOTARI Table 2 in Appendix VI.

The 2 Synthesised Findings state that:

- Health professionals, at all levels, who are involved in the care of older adults, need to understand their clients in context; how the problems they currently experience may be related to sexual abuse in childhood and the dynamic consequences of that abuse across the older person's entire life course.
- Health professionals should use their understanding of the context of their older clients' lives; which may include sexual abuse during childhood, to guide care within an optimised professional therapeutic alliance based on safety for both the older adult and the health professionals.

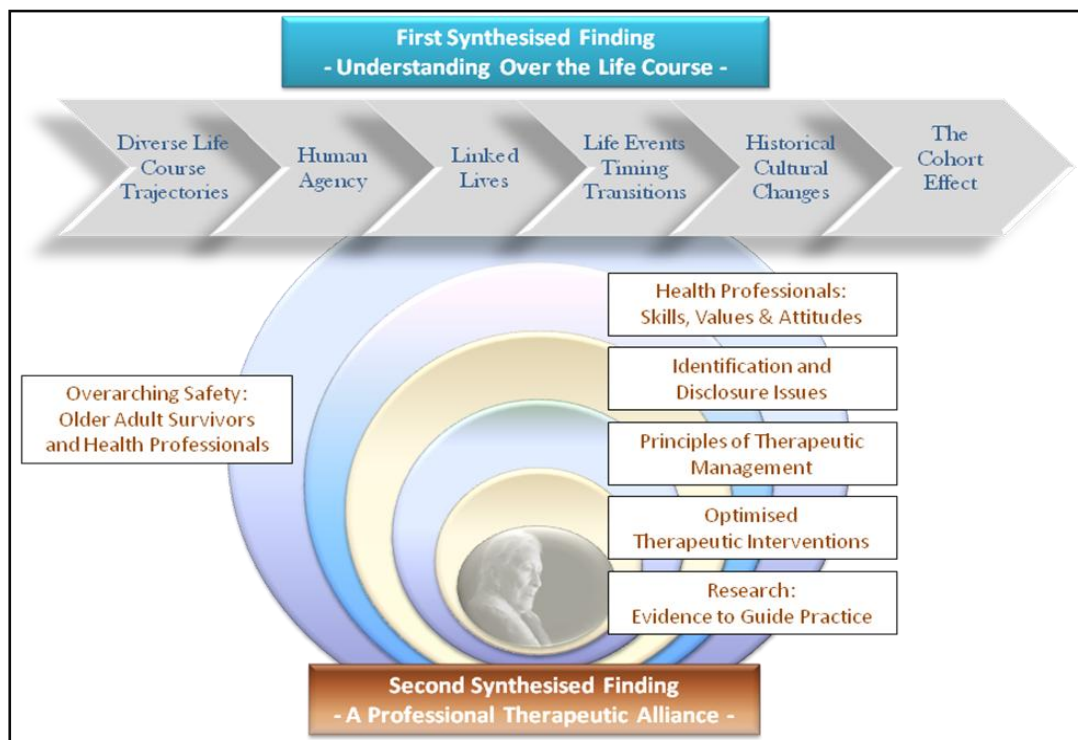
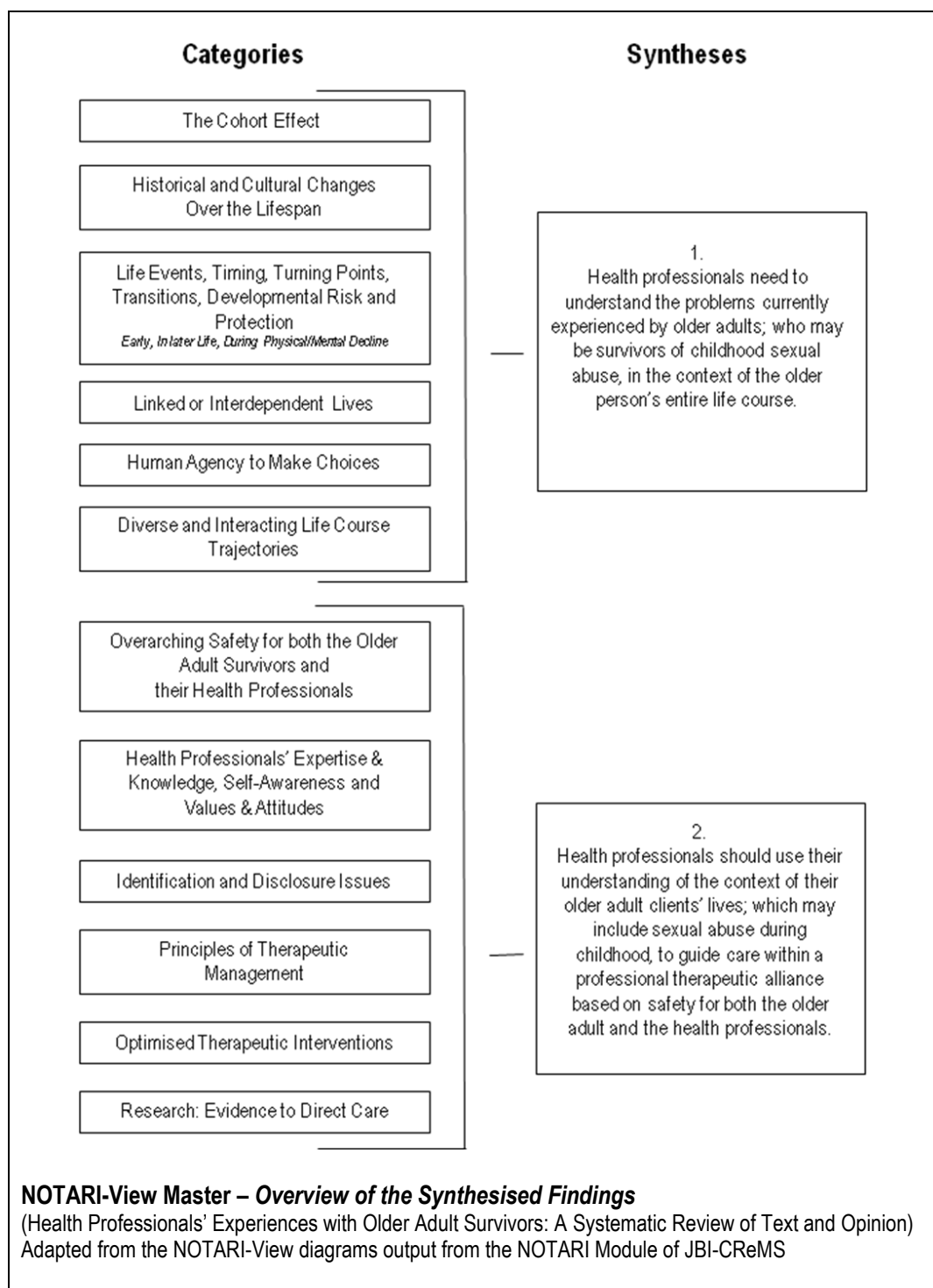


Figure I. Overview of the 2 Synthesised Findings



The First Synthesised Finding – *Contextual Understanding*

The basic theme of the first synthesised finding is that health professionals, at all levels, who are involved in the care of older adults, need to understand their clients in context; how the problems they currently experience may be related to sexual abuse in childhood and the dynamic consequences of that abuse across the older person's entire life course.

The problems suffered by older adults are not necessarily the result of aging; although they may be reactivated or exacerbated by the losses and changes likely to occur in older age, but may have their origins in earlier times, even with sexual abuse in childhood.

While causal models directly relating problems in older age to childhood sexual abuse are too simplistic and unproven, problems emerging in old age may have their roots as far back as childhood in the complex relational and social contexts that allowed sexual abuse to happen, as well as the characteristics of the abuse itself such as the age of the child, relationship to the perpetrator, length and severity of the abuse and availability of other support (see the previous *Background* section for an overview of childhood sexual abuse issues and Relational Table 1.2 *The Abuse and Consequences*, in Appendix I, for the specific abuses done to the 38 older adult survivors described).

As well as the abuse done to the child, health professionals need to understand the older adult survivor in various individual, social and cultural contexts played out over decades, and the interactions, accumulations, moderating and mediating events and processes within different developmental stages and across time.

The Conceptual Framework for the First Synthesised Finding

The first synthesised finding is made up of six major categories that have been interpretatively aggregated from 131 of the findings identified in the 26 texts. The six categories; while having evolved from the 26 texts are framed with reference to the concepts and themes of the Life Course Perspective as described by Hutchinson.⁵⁴ This perspective was chosen because it seemed an excellent fit to the findings emerging from the texts on the relationships between life events and the current problems experienced by older adult survivors.

Hutchinson provides an historical overview of the Life Course Perspective, with its roots in developmental theory and social history, including the continuing influential work of Glen Elder Junior. Hutchinson says that, *“The life course perspective is a theoretical model that has been emerging over the last 45 years, across several disciplines. ... the life course perspective calls attention to how historical time, social location, and culture affect the individual experience of each life stage”*.⁵⁴ The conceptual focus is on identifying dynamic processes such as interacting, temporal pathways and accumulating risk and protection, rather than on establishing causality.

The basic concepts and themes of the Life Course Perspective, as defined by Hutchinson, have been used in the construction of the framework for the First Synthesised Finding. The **concepts** used are those of cohort, transition, trajectory, life event and turning point.⁵⁴

According to Hutchinson:

- A cohort is a group of people *“who were born at the same historical time and who experience particular social changes within the given culture in the same sequence and at the same age”*.
- A transition is a *“change in roles and statuses that represents a distinct departure from prior roles and statuses”*.
- A trajectory is a *“long-term pattern of stability and change, which usually involves multiple transitions”*.
- A life event is a *“significant occurrence involving a relatively abrupt change that may produce serious and long-lasting effects”*.
- A turning point is a *“life event that produces a lasting shift in the life course trajectory”*. A turning point may only be apparent well after the event.⁵⁴

In the Life Course Perspective, as described by Hutchinson, these concepts are the basis of major **themes** that have also been used in the construction of the framework for the First Synthesised Finding.⁵⁴ These themes include:

- The interplay of human lives and historical time where *“individual and family development must be understood in historical context”*. This theme includes effects caused by belonging to a particular birth cohort, the cohort effect. It also includes the impact of other social and historical changes over the lifespan.
- The timing of lives where *“particular roles and behaviors are associated with particular age groups, based on biological age, psychological age, social age, and spiritual age”*. When a transition does not occur at the typical age then it is

referred to as “off time”.

- Linked or interdependent lives where *“human lives are interdependent, and the family is the primary arena for experiencing and interpreting wider historical, cultural, and social phenomena”*.
- Human agency in making choices where the *“individual life course is constructed by the choices and actions individuals take within the opportunities and constraints of history and social circumstances”*.
- Diversity in life course trajectories because of *“cohort variations, social class, culture, gender, and individual agency”*.
- Developmental risk and protection where *“experiences with one life transition have an impact on subsequent transitions and events, and may either protect the life course trajectory or put it at risk”*.⁵⁴

The six major categories that make up the First Synthesised Finding, and that have evolved out of the texts with reference to Life Course Perspective theories as described above, include:

- 1.1 The Cohort Effect
- 1.2 Historical and Cultural Attitudes and Changes over the Life Span
- 1.3 Life Events, Timing, Turning Points, Transitions, Developmental Risk and Protection: *Early in Life, In Older Age, During Physical/Cognitive Decline*
- 1.4 Linked or Interdependent Lives
- 1.5 Human Agency to Make Choices
- 1.6 Diverse and Interacting Life Course Trajectories

These are dynamic rather than distinct categories that influence and interact with each other over time. The first five categories are also integrated into the final category that highlights the diversity of various life course trajectories. The findings from the texts that make up these categories are discussed in the following sections.

1.1 THE COHORT EFFECT

The first major category is the cohort effect. The interplay of human life and historical time in early life, has influenced the basic values, attitudes and even abuse constructs over the lifespan of these older adult survivors, reinforcing their relative and absolute silence and continuing to influence the choices they make in older age, especially their choices to seek and accept help, and their relationships with health professionals usually born in an era with values somewhat different to their own.⁵⁵

This category has been constructed from 14 findings identified from 10 of the texts, about the values and attitudes of older adult survivors, generally born between the two world wars, and how those values have influenced their ability to talk about their abuse and to seek help. These findings also form four themes that include: the silence surrounding sexual topics within the family and society, the lack of a construct or even a language to talk about childhood sexual abuse, the fundamentally different socioeconomic structure and dynamics of the family in past decades and the stigma attached to seeking help for emotional problems.

1.1.1 *Silence*

In earlier times when these older adult survivors were children, sexual matters were not generally discussed within the family and not seen as appropriate for public discussion. Bergström-Walan states that *“senior citizens ... grew up in a period in which sexuality was a taboo subject and there was little or no discussion of sexual difficulties within families”*.⁵⁶ Altschuler (1996) says that *“... today’s generation of older women grew up in a climate where language and topics pertaining to sexuality were not appropriate for public conversations”*.⁵⁷ The silence surrounding sexual matters within the family could even extend to mothers not discussing the onset of menstruation with their daughters.⁴⁷

1.1.2 *Lack of a Language or Construct to Talk about ‘It’*

The lack of a construct to understand and talk about childhood sexual abuse is more than the silence described above; it is a fundamental disconnection between experiencing

abuse, giving meaning to that experience and being able to talk about it. Older adult survivors may have suffered emotional distress for most of their lives, with no clear concept of the reason for their distress.⁵⁶ Sutton describes how “... *some people cannot talk about it because they do not know what ‘it’ is. How can someone talk about that which is much bigger than they; about experiences that were never constructed or acknowledged by society but which hurt them so badly*”.⁵² Many older women grew up believing that the ‘it’ that they had experienced was ‘normal’, and occurred in most families.⁵¹

McInnes-Dittrich discusses the difficulties that the lack of such a fundamental construct can have for older female survivors who enter therapy, where “... *defining an incestuous or exploitative sexual relationship in their childhood as sexual abuse may be confusing, ambiguous, or too threatening to be processed through life review or any other therapeutic intervention*”.⁵⁰

1.1.3 Different Family Dynamics and Structures

Family dynamics were fundamentally different in earlier times. The role and power of the father or husband was such that his inadequacy, unavailability or loss could result in extreme poverty that even threatened survival. Rosik discusses an older female survivor’s family of origin who “...*became impoverished at the loss of its sole breadwinner and survived in a state of abject poverty and often on one meal a day*”.⁵⁸

Girls often took on adult roles at a younger age because of the loss or dependency of their mother, and the only way to escape their abusive father and dependent family may have been to marry young.^{55, 58-60} The older female survivor described by Crose, at the age of fourteen married a widower; who she did not love, with several small children, because he needed someone to care for his children and she needed protection from her sexually abusive father.⁵⁹

1.1.4 The Stigma of Seeking Help for Psychological Problems

Older adult survivors grew up in an era when help was not usually sought for psychological problems because, if they did seek help, then this carried the stigma of mental illness. Bergström-Walan discusses the situation in Northern Europe with reference to the survivor Mary, “... *when Mary was in her 30s and 40s (the period of life when people normally are*

referred for psychotherapy), it was unusual in northern Europe to seek psychological help. At that time, it was embarrassing to be recognized as having a psychological problem without being diagnosed as mentally ill".⁵⁶ The American Depression cohort, as described by Davenport, are still reluctant to seek psychological help; "Older adults of the Depression generation especially are not prone to share their emotional pain, voluntarily go to a mental health therapist, or have an accurate memory of early life experiences".⁶¹

Table 1.1 The Cohort Effect

Findings that make up this Category and Illustrations from the Texts

#	Finding	Illustration From the Text
2	Older women of today grew up in an era where language and topics about sexuality were not considered appropriate for public conversations.[C]	"...today's generation of older women grew up in a climate where language and topics pertaining to sexuality were not appropriate for public conversations." (page 52)
5	Older adults frequently have difficulties seeking help for sexual problems because they grew up in an era in which sexuality was a taboo subject with little or no discussion within the family.[C]	"Senior citizens more frequently have difficulties in seeking help with their sexual problems....They grew up in a period in which sexuality was a taboo subject and there was little or no discussion of sexual difficulties within families." (page 32)
5	Older adults did not usually seek psychological help earlier in their lives because at that time a psychological problem was stigmatised with a diagnosis of mental illness.[C]	"One might ask why Mary did not seek therapy earlier, since throughout her life she had felt unwell. However, when Mary was in her 30s and 40s (the period of life when people normally are referred for psychotherapy), it was unusual in northern Europe to seek psychological help. At that time, it was embarrassing to be recognised as having a psychological problem without being diagnosed as mentally ill." (page 34-35)
8	At the time of the abuse, there was no public awareness that sexual abuse by clergy was possible or likely and it was even believed to be morally desirable to have children spend time with their parish priest.[c]	"Unlike today, at the time of the abuse, there was no public awareness that sexual abuse by clergy was possible or likely. Having children spend time with the parish priest was thought to be a way of instilling highly valued moral and religious values." (page 344)
8	In earlier times, sexuality was a highly private matter not discussed in public, or even within the family, with some mothers not even discussing menstruation with their daughters. [U]	"All aspect of sexuality were considered to be highly private matters that were not discussed in public. Mother, in particular, was extremely modest and unable or unwilling to discuss sexual matters, including the onset of menstruation, with her daughters." (page 344)

9	In the early part of the century, when very young girls married, they were often escaping sexual abuse at home. [C]	"In the early part of the century when very young teen-age girls married, they often were escaping an abusive situation at home ... Edna, ... who, at age 14, married the widower with several small children, was not in love with her much older mate. Her husband needed a woman to take care of his children, and she needed a protector from a sexually abusive father." (page 66)
10	Older adults, especially those who grew up during the Depression, are not prone to share their emotional pain, seek help for mental health issues, or even have an accurate memory of their early life experiences. [C]	"Older adults of the Depression generation especially are not prone to share their emotional pain, voluntarily go to a mental health therapist, or have an accurate memory of early life experiences." (page 15)
16	Older women grew up in a time when women's voices were rarely heard and exploitation in the home and at work was common. [C]	"Older women grew up in a time when women's voices were rarely heard and exploitation of women in the home and at work was common." (page 171)
16	Older women survivors may find it too confusing or ambiguous to define an incestuous or exploitive sexual relationship in childhood as abuse. [C]	"For the birth cohort of older women who are survivors of childhood sexual abuse, defining an incestuous or exploitative sexual relationship in their childhood as sexual abuse may be confusing, ambiguous ..." (page 171)
16	Older women may find it too threatening to process their childhood sexual abuse through any therapeutic intervention. [C]	"... or too threatening to be processed through life review or any other therapeutic intervention." (page 171)
20	Older women were born in a time when abuses against women were common, and many grew up believing that abuse was normal and occurred in most families. [C]	"Today's older woman was born in 1945 or earlier, a time when abuses against women were common. Many of these women grew up believing that abuse was normal and occurred in most families." (page 100)
21	The stories of older women survivors reflect an era far different from that experienced by their therapist. [U]	"Their stories reflect an era far different from the one I worked in as a new MSW." (page 75)
22	For earlier cohorts, the loss of the father, usually the sole breadwinner, could result in impoverishment for the family. [U]	"The family became impoverished at the loss of its sole breadwinner and survived in a state of abject poverty and often on one meal a day." (page 304)
24	Older adult survivors may not be able to talk about abuse, because they grew up in a society that did not acknowledge 'it' or provide a construct, including a language, to talk about 'it'. [C]	"...some people cannot talk about it because they do not know what 'it' is. How can someone talk about that which is much bigger than they; about experiences that were never constructed or acknowledged by society but which hurt them so badly?" (page 169)

Refers to the Paper or Text Number from **Master Table 1. The Master Table of Texts**, in Appendix I
[U] = Unequivocal – beyond reasonable doubt; [C] = Credible – plausible in light of the information

Findings

Older women of today grew up in an era where language and topics about sexuality were not considered appropriate for public conversations.

Older adults frequently have difficulties seeking help for sexual problems because they grew up in an era in which sexuality was a taboo subject with little or no discussion within the family.

Older adults did not usually seek psychological help earlier in their lives because at that time a psychological problem was stigmatised with a diagnosis of mental illness.

At the time of the abuse, there was no public awareness that sexual abuse by clergy was possible or likely and it was even believed to be morally desirable to have children spend time with their parish priest.

In earlier times, sexuality was a highly private matter not discussed in public, or even within the family, with some mothers not even discussing menstruation with their daughters.

In the early part of the century, when very young girls married, they were often escaping sexual abuse at home.

Older adults, especially those who grew up during the Depression, are not prone to share their emotional pain, seek help for mental health issues, or even have an accurate memory of their early life experiences.

Older women grew up in a time when women's voices were rarely heard and exploitation in the home and at work was common.

Older women survivors may find it too confusing or ambiguous to define an incestuous or exploitive sexual relationship in childhood as abuse.

Older women may find it too threatening to process their childhood sexual abuse through any therapeutic intervention.

Older women were born in a time when abuses against women were common, and many grew up believing that abuse was normal and occurred in most families.

The stories of older women survivors reflect an era far different from that experienced by their therapist.

For earlier cohorts, the loss of the father, usually the sole breadwinner, often resulted in impoverishment for the family.

Older adult survivors may not be able to talk about abuse, because they grew up in a society that did not acknowledge 'it' or provide a construct, including a language, to talk about 'it'.

Categories

1.1 The Cohort Effect

NOTARI-View 1.1 - Synthesis 1: Category 1 - *The Cohort Effect*

(Health Professionals' Experiences with Older Adult Survivors: A Systematic Review of Text and Opinion)

Adapted from the NOTARI-View diagrams output from the NOTARI Module of JBI-CReMS

1.2 HISTORICAL AND CULTURAL CHANGES OVER THE LIFE SPAN

Historical and cultural changes over the life span, for instance the influence of the mass media and a more supportive society, have empowered older adult survivors, especially women, to break their silence. Still many of these older adult survivors are slow to change, often resigning themselves to their 'lot', feeling more comfortable with medical models of treatment while being seen as unattractive and bothersome by many in society.

This category has been constructed from 11 findings identified from eight of the texts, about the influence that historical and cultural changes have had on older adult survivors over their life span. Within this major category there are four themes about how older adult survivors see themselves and seek help. These include: older adults' resignation and slowness to change; individual, cultural and societal attitudes; societal and legal changes and the influence of the mass media.

1.2.1 *Slow to Change*

While there has been considerable change in cultural and societal values and attitudes over the last half century, older adults may be slower to change, perhaps because of their basic cohort values amplified by age and cohort related resignation. Bergström-Walan proposes that *"... people in younger and middle-aged groups from all classes of society, are no longer ashamed of seeking help for psychological problems. Among elderly people, the situation has changed less. They resign themselves to their situation and accept their medical practitioners' prescription of tranquillisers instead of seeking help from a psychotherapist".*⁵⁶ While arguably, younger people are *"no longer ashamed"* to seek psychological help, older adults are more likely to seek medical rather than psychological help.

1.2.2 *Individual, Cultural and Societal Attitudes*

Some older adult survivors may be relatively unsophisticated, having always lived in remote rural communities where, although childhood sexual abuse may not be uncommon, there may be little exposure to the mental health system and they are unlikely to seek or receive psychological help.⁵⁰

Older adult survivors' positive cultural attitudes about themselves, such as their body image, can be tainted by stressors related to their childhood abuse. Altschuler and Katz (2010) discuss the case of an older female survivor who had considered herself to be an *"attractive big"*⁶² Afro-American woman, until she had to take on the personal care of her mother, who she blamed for not protecting her from her sexually abusive step-father. She began to overeat, and her positive body image changed so that she came to see herself as fat and unattractive.⁶²

Ageism is another pervasive cultural attitude that may result in a cruel circularity as society tries to soften the negative message that it sends to the elderly, who may also be survivors. Walter writes that *"our societal stereotype of the elderly as unlovable, unattractive, and bothersome does nothing for an elder's self-esteem ... in an effort to preserve self-esteem, society encourages the elderly to see themselves in terms of who they have been. Unfortunately for the elderly survivor of incest, this includes being a victim"*.⁶³

In other cultures, such as the Hispanic culture, issues that could be related to childhood sexual abuse, such as dissociative disorders, may be *"interpreted and treated through culturally sanctioned methods such as those associated with possession syndrome"*.⁵⁸ Acculturation, however, may result in an older adult survivor of Hispanic origin, accepting the dominant cultural medical model. In the case described by Rosik, this resulted in a complete failure by health professionals, over many years, to identify a severe dissociative disorder that was manifest in 'blackouts' and somatic complaints, resulting in numerous unnecessary operations.⁵⁸

1.2.3 Societal and Legislative Changes

Capasso highlights the changes that have occurred in American society whereby the *"... memory of sexual abuse emerges in the context of a society that now acknowledges the atrocity of sexual abuse of children, punishes paedophiles, and accepts and supports victims of sexual abuse"*.⁶⁴ These societal changes are relatively widespread.

Less widespread is legislative change to allow prosecution of abusers decades after the event. In the paper by Colarusso where, for legal reasons, he assessed four sisters sexually abused decades before by their parish priest, this was only made possible

because “... a law was passed in California that allowed older victims of childhood sexual abuse to sue the church”.⁴⁷

1.2.4 The Information Revolution

The information revolution means that the subject of childhood sexual abuse now receives widespread media exposure, which may prompt older adult survivors to question their own problems and start to link them to their abuse in childhood and to seek appropriate help.⁵⁶ The media may also make older adult survivors realise that they were not the only ones who experienced abuse, such as abuse by the clergy, and to make them feel responsible to expose the truth to stop it happening to others.⁴⁷ Very popular television talk shows like the Oprah Winfrey Show, have allowed older female survivors to see other women talking openly about their abuse which has normalised their feelings and empowered them to finally talk about their own abuse.⁵¹

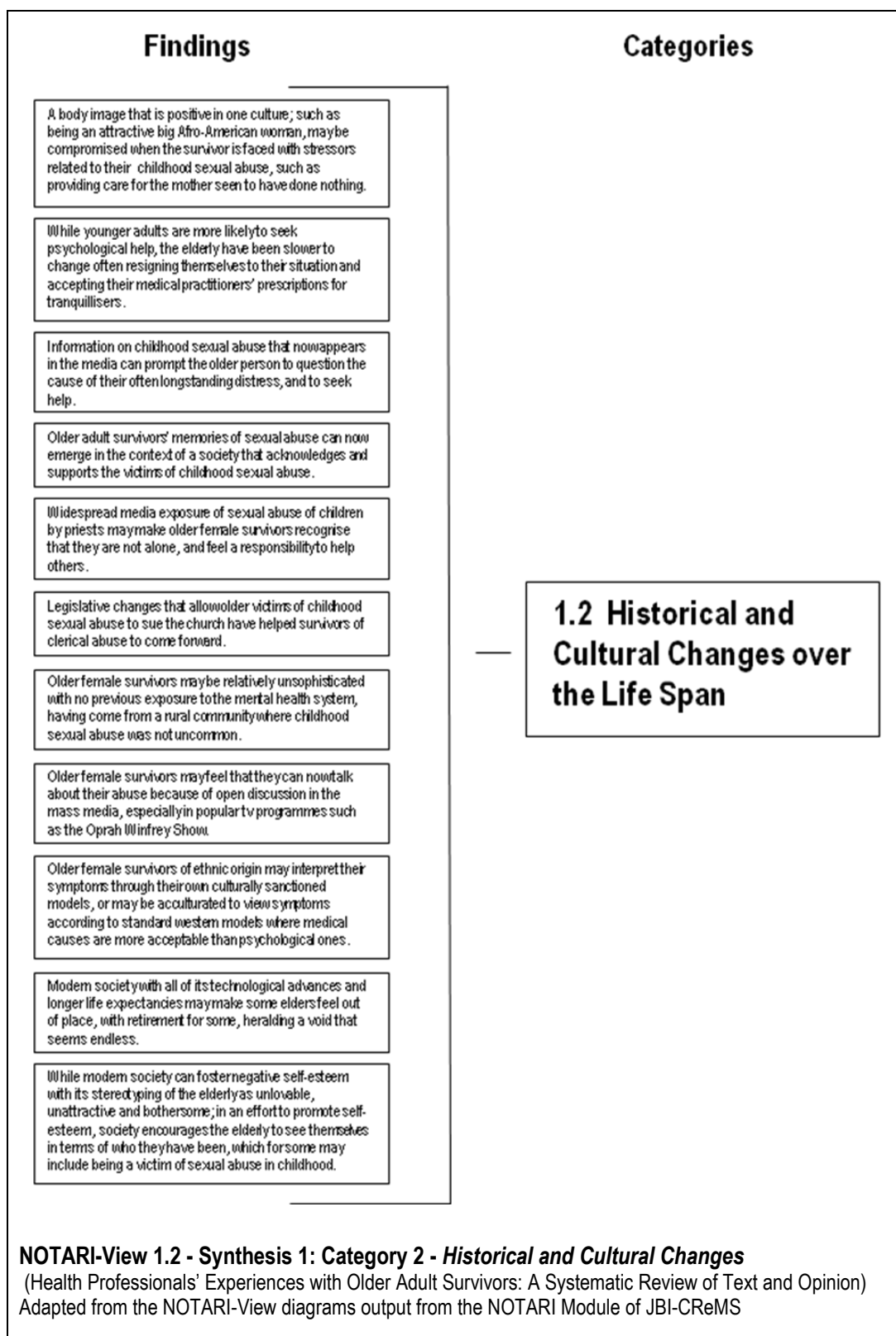
Table 1.2 Historical and Cultural Changes over the Life Span –

Findings that make up this Category and Illustrations from the Texts

#	Finding	Illustration from Text
3	A body image that is positive in one culture; such as being an attractive big Afro-American woman, may be compromised when the survivor is faced with stressors related to their childhood sexual abuse such as providing care for the mother seen to have done nothing. [C]	“Before starting to care for her mother, she considered herself an ‘attractive big [Afro-American] woman’. Now she described herself as ‘fat’ and ‘unattractive’.” (page 206)
5	While younger adults are more likely to seek psychological help, the elderly have been slower to change often resigning themselves to their situation and accepting their medical practitioners’ prescriptions for tranquillisers. [C]	“Most people in younger and middle-aged groups from all classes of society, are no longer ashamed of seeking help for psychological problems. Among elderly people, the situation has changed less. They often resign themselves to their situation and accept their medical practitioners’ prescriptions of tranquillisers instead of seeking help from a psychotherapist.” (page 35)
5	Information on childhood sexual abuse that now appears in the media can prompt the older person to question the cause of their often longstanding distress, and to seek help. [U]	“One year before coming to see me she had seen my name mentioned in an advertisement about psychotherapy for victims of child abuse. This had prompted her to wonder whether her own fear and distress could be connected with her early childhood experience.” (page 33)

7	Older adult survivors' memories of sexual abuse can now emerge in the context of a society that acknowledges and supports the victims of childhood sexual abuse. [C]	"The memory of sexual abuse emerges in the context of a society that now acknowledges the atrocity of sexual abuse of children, punishes pedophiles, and accepts and supports victims of sexual abuse." (page 228)
8	Widespread media exposure of sexual abuse of children by priests may make older female survivors recognise that they are not alone, and feel a responsibility to help others. [U]	"... she began to hear about sexual abuse in the church from newspapers and TV shows and recognized that she and her sisters were not the only ones who had been injured. Feeling a responsibility to others, Anna called her sisters and discussed the matter." (page 328)
8	Legislative changes that allow older victims of childhood sexual abuse to sue the church have helped survivors of clerical abuse to come forward. [U]	"When a law was passed in California that allowed older victims of childhood sexual abuse to sue the church, all four siblings agreed to sue." (page 328)
16	Older female survivors may be relatively unsophisticated with no previous exposure to the mental health system, having come from a rural community where childhood sexual abuse was not uncommon. [C]	"These women were relatively unsophisticated. None of the women had previous exposure to the mental health system. They lived in an environment where childhood sexual abuse was not uncommon." (page 172)
20	Older female survivors may feel that they can now talk about their abuse because of open discussion in the mass media, especially in popular tv programmes such as the Oprah Winfrey Show. [U]	"She stated that it was time to talk about the sexual abuse, "because it is the 1990's and people don't keep it a secret any more. I have heard people talking about it on Oprah...."" (page 105)
22	Older female survivors of ethnic origin may interpret their symptoms through their own culturally sanctioned models, or may be acculturated to view symptoms according to standard western models where medical causes are more acceptable than psychological ones. [C]	"Having been fairly acculturated [Hispanic] the patient was comfortable interpreting her psychiatric symptoms according to standard medical etiological models. ... One may assume that in different cultures the dissociative phenomena would be interpreted and treated through culturally sanctioned methods such as those associated with possession syndrome." (page 65)
26	Modern society with all of its technological advances and longer life expectancies may make some elders feel out of place, with retirement for some, heralding a void that seems endless. [C]	"Furthermore, the meaning of aging is highly individualized and personal. With technological advances, many elders may feel out of place in our society. Retirement with longer life expectancies may herald a void that seems endless to some." (page 15)
26	While modern society can foster negative self-esteem with its stereotyping of the elderly as unlovable, unattractive and bothersome; in an effort to promote self-esteem, society encourages the elderly to see themselves in terms of who they have been, which for some may include being a victim of sexual abuse in childhood. [C]	"Our societal stereotype of the elderly as unlovable, unattractive, and bothersome does nothing for an elder's self-esteem..... in an effort to preserve self-esteem, society encourages the elderly to see themselves in terms of who they have been. Unfortunately for the elderly survivor of incest, this includes being a victim." (page 15)

Refers to the Paper or Text Number from **Master Table 1. The Master Table of Texts**, in Appendix I
[U] = Unequivocal – beyond reasonable doubt; [C] = Credible – plausible in light of the information



1.3 LIFE EVENTS AND THEIR TIMING, TRANSITIONS AND TURNING POINTS, DEVELOPMENTAL RISK AND PROTECTION:-

Early in Life, In Older Age and During Physical and/or Cognitive Decline

Early adverse life events such as childhood sexual abuse and the circumstances that made it possible, may have had a significant negative impact on the life course of older adult survivors, often with “off time” transitions whereby the survivor may have been forced to assume adult roles prematurely. However, while childhood sexual abuse does not inevitably lead to a path of suffering and poor health outcomes, the processes set in train early, especially if the abuse was severe, can interact with future events to accumulate and cascade across the lifespan resulting in differential vulnerabilities, risks and also protective factors for survivors as they age. Finally the older adult survivor will face the developmental tasks and losses of old age with the baggage of their accumulated risks and unresolved lifespan issues, however, armed with the resilience of decades of survival.

1.3.1 Early in Life

1.3.1.1 Severity, Verbal Threats, Physical Force, Emotional Abuse and Neglect

Colarusso, when discussing the sisters who were abused by their catholic priest, states that while all the pathology they exhibit cannot be “*attributed solely to the sexual abuse*”,⁴⁷ because of the severity of the abuse and the verbal threats and physical force that the priest used, all major developmental tasks from adolescence through midlife were compromised.⁴⁷ However, Colarusso also notes that the parents while unaware of the abuse and so unable to protect the girls, were probably “*a stabilising constant*” in the girls’ early lives.⁴⁷ As well as the severity and length of the childhood sexual abuse, Rosik also implicates the co-existence of emotional abuse and neglect in the development of problems into older age.⁵⁸

1.3.1.2 Accumulation of Risk within Dysfunctional Childhood Environments

Accumulation of developmental risk is a frequent theme in the early lives of many of the 38 older adult survivors described in the review texts. Gagnon and Hersen highlight the impact that childhood sexual abuse can have in setting “*the foundation for emotional, cognitive, and behavioural vulnerabilities that may or may not lead to psychopathology in adulthood, depending on the subsequent influence of life events and circumstances*”.⁴⁸

However, childhood sexual abuse rarely occurs in isolation, but within the framework of a dysfunctional childhood and family of origin. Davenport discusses how the early life of one older female survivor, living in a very dysfunctional family, resulted in her having few *“interactive social skills”* that contributed to molestation during adolescence that *“reinforced her fearful, defensive, almost paranoid nature”*.⁶¹ While this older female survivor was not sexually abused within her family, the emotional abuse and neglect she suffered set in train later sexual abuse outside the family, and the further accumulation of vulnerabilities and psychopathology into old age.

Many of the texts contain examples of unimaginable abuse, within extremely dysfunctional environments.^{51, 58, 65-67} Hill in his paper, *“The Man Who Claimed to be a Paedophile”*,⁶⁵ describes the early life of an older male survivor who was brought up in an orphanage, after being rejected by his prostitute mother, where he was sexually abused by older boys. His life course was subsequently beset with substance abuse, severe social isolation, psychotic episodes, paedophilia and finally abuse of his pet dog.⁶⁵

1.3.1.2 Early or “Off Time” Transitions

Several of the texts illustrate how childhood sexual abuse was implicated in early or “off time” transitions into marriage and adult roles, which then cascaded into subsequent negative lifelong problems such as depression and re-victimisation.^{46, 55, 60} The older female survivor described by Allers and colleagues, who at 14, married to escape her abusive grandparents, was married early even for the norms of her generation.⁴⁶

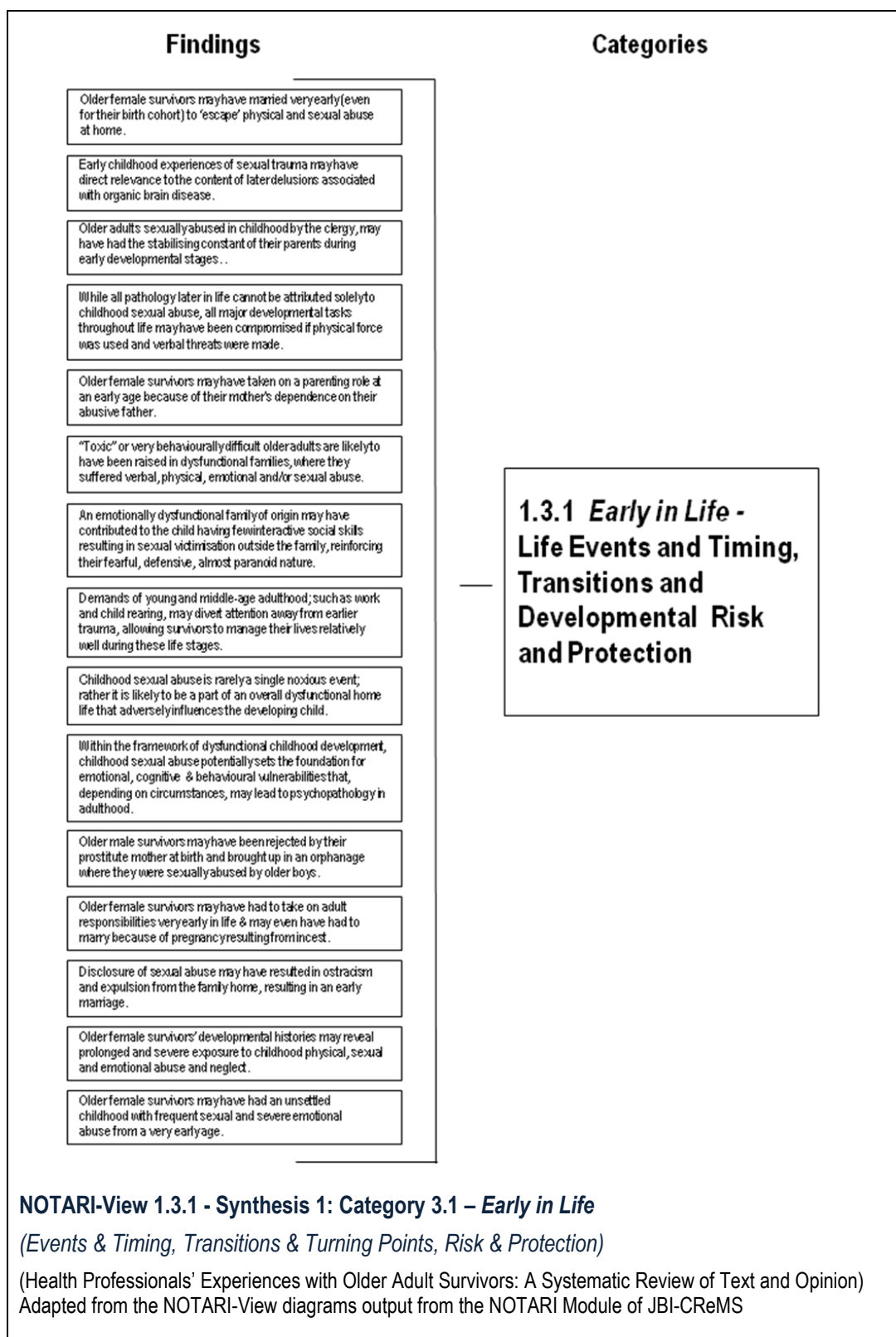
Even when marriage was not particularly early it may have been seen as an escape from abuse, or as a necessity because of pregnancy resulting from incestuous abuse⁶⁰ or because the victim had to marry to survive, after being ostracised by her family for disclosing the abuse.⁵⁵ As a child, the older female survivor may also have had to assume a parenting role because of the dependency of the non abusive parent, usually the mother⁶¹ which may have entailed caring for her entire family.⁶⁰

Table 1.3.1 Early in Life – Events, Timing, Transitions, Risk and Protection

Findings that make up this Category and Illustrations from the Texts

#	Finding	Illustration from the Text
1	Older female survivors may have married very early (even for their birth cohort) to 'escape' physical and sexual abuse at home. [U]	"After 4 weeks of psychotherapy, she disclosed that she had been physically abused by her grandmother and sexually abused by her grandfather until she married at the age of 14 years." (page 15)
6	Early childhood experiences of sexual trauma may have direct relevance to the content of later delusions associated with organic brain disease. [C]	"A 66-year-old female believed her husband was having numerous affairs with women in the neighbourhood. She questioned him continually. Three years previously Alzheimer's disease was diagnosed. ... In childhood she was physically and sexually abused by her stepfather, ... From the age of 8 she was instructed by her mother to follow and report on the women he was seeing." (page 704) "... the early experiences of Case 2 may have direct relevance to her later jealousy." (page 706)
8	Older adults sexually abused in childhood by the clergy, may have had the stabilising constant of their parents during early developmental stages. [C]	"Although they saw few signs of outward affection between the parents, father and mother were clearly close to each other and a stabilizing constant in the children's lives." (page 344)
8	While all pathology later in life cannot be attributed solely to childhood sexual abuse, all major developmental tasks throughout life may have been compromised if physical force was used and verbal threats were made. [C]	"... all of the pathology found in these women cannot be attributed solely to the sexual abuse....Physical force was used and verbal threats were made. All major developmental tasks from adolescence through midlife were compromised by the sexual abuse." (page 343)
10	Older female survivors may have taken on a parenting role at an early age because of their mother's dependence on their abusive father. [U]	"For years T had disdainfully watched her mother go after her father and bring him back, always for more suffering. Then one day as a teenager, T could stand it no longer. She physically stood in the doorway to block her mother from again following her father." (page 149)
10	"Toxic" or very behaviourally difficult older adults are likely to have been raised in dysfunctional families, where they suffered verbal, physical, emotional and/or sexual abuse. [C]	"Few toxic agers are raised in an environment that is loving, open, caring, and accepting.... Toxics are more likely to be raised in an environment that is abusive, either verbally, physically, emotionally, or sexually." Page (139)
10	An emotionally dysfunctional family of origin may have contributed to the child having few interactive social skills resulting in sexual victimisation outside the family, reinforcing their fearful, defensive, almost paranoid nature. [C]	"With no siblings or other children to socialize with, T learned few interactive social skills," (page 149) "In her preteens T was sexually molested by "some boys," which reinforced her fearful, defensive, almost paranoid nature." (page 150)
13	Demands of young and middle-age adulthood; such as work and child rearing, may divert attention away from earlier trauma, allowing survivors to manage their lives relatively well during these life stages. [C]	"Perhaps the demands of young and middle-age adulthood, such as work and child rearing, divert attention away from earlier trauma, allowing many survivors of CSA to manage their lives relatively well during these life stages." (page 188)

13	Childhood sexual abuse is rarely a single noxious event; rather it is likely to be a part of an overall dysfunctional home life that adversely influences the developing child. [C]	"CSA is rarely a discrete noxious event; rather, it is more likely to be a component of an overall dysfunctional home life which exerts a great influence on the developing child." (page 189)
13	Within the framework of dysfunctional childhood development, childhood sexual abuse potentially sets the foundation for emotional, cognitive and behavioural vulnerabilities that, depending on circumstances, may lead to psychopathology in adulthood. [C]	"Within this developmental framework [disrupted and maladaptive childhood development], CSA potentially sets a foundation for emotional, cognitive, and behavioural vulnerabilities that may or may not lead to psychopathology in adulthood, depending on the subsequent influence of life events and circumstances..." (page 190)
15	Older male survivors may have been rejected by their prostitute mother at birth and brought up in an orphanage where they were sexually abused by older boys. [U]	"He was rejected at birth by his prostitute mother and was brought up by nuns in a Roman Catholic orphanage. During this time he was sexually abused by older boys." (page 137)
18	Older female survivors may have had to take on adult responsibilities very early in life and may even have had to marry because of pregnancy resulting from incest. [U]	"After primary school, at the age of 11, she cared for the whole family. At 16 she left home to work in a factory, until her marriage in 1923 to a farmer when she was 18 years old. ...The marriage to the farmer was precipitated by her pregnancy following an incestuous relationship with her father..." (page 143)
21	Disclosure of sexual abuse may have resulted in ostracism and expulsion from the family home, resulting in an early marriage. [U]	"Mrs. S. also revealed that when she finally divulged the abuse to her mother, she was ostracized and forced to leave. This resulted in an early marriage and a final "escape from my stepfather."" (page 77)
22	Older female survivors' developmental histories may reveal prolonged and severe exposure to childhood physical, sexual and emotional abuse and neglect. [U]	"The patient's developmental history revealed prolonged and severe exposure to physical, sexual and emotional abuse as well as neglect [childhood]." (page 63)
23	Older female survivors may have had an unsettled childhood with frequent sexual and severe emotional abuse from a very early age. [U]	"She had an unsettled childhood with tantrums and was subjected to regular sexual abuse by her father from the age of around 4-5 years... She was repeatedly told she was a bad and an unwanted child and would 'burn in hell' for her 'sins'." (page 304)
<p># Refers to the Paper or Text Number from Master Table 1. The Master Table of Texts, in Appendix I</p> <p>[U] = Unequivocal – beyond reasonable doubt; [C] = Credible – plausible in light of the information</p>		



1.3.2 In Older Age

1.3.2.1 Bereavement

The loss of a close family member or peer may be the life event that precipitates or intensifies older adult survivors' symptoms; such as depression, that are possibly related to unresolved childhood sexual abuse.^{43, 46} However, the grief may be complicated by feelings of guilt, arising from complex relationship issues that can never be fixed now that the loved one has died. In the case described by Benbow and Jagus, the grief felt by the older female survivor after the death of her "*much loved*" husband, was intensified by unresolved sexual problems arising out of her childhood sexual abuse.⁴³

Cruse highlights another possible facet to the complex issues that can surround bereavement, when she talks about an older female survivor who became suicidal when the husband she married; unhappily, to escape abuse as a child, appeared to be going to die before her abusive very elderly father.⁵⁹

The death of the abuser may also trigger a complicated bereavement, especially if it results in the emergence of memories of childhood sexual abuse for the first time.⁶⁸

1.3.2.2 Loss of Roles and Resources

Allers and colleagues argue that older adult survivors may have increased difficulty coping with issues related to unresolved childhood sexual abuse because they no longer have the distractions of earlier roles and resources, compounded by the loss of peer support and physiological changes that occur in later life.⁴⁶ Gagnon and Hersen (who have cited Allers et al) support this argument when they propose that "*the demands of young and middle-age adulthood, such as work and child rearing, divert attention away from earlier trauma, allowing many survivors of CSA to manage their lives relatively well during these life stages*".⁴⁸ Walter sees these losses as similar to the "*emotions evoked during the incestuous relationship, perhaps causing a resurgence of incestuous memories*".⁶³

1.3.2.3 Retirement, Discontinuation of Maladaptive Coping Mechanisms

Gagnon and Hersen discuss how tasks and transitions occurring in older age, such as a retirement, life review (a developmental task of old age), and perhaps the discontinuation of

maladaptive coping mechanisms such as the abuse of alcohol, may interact to exacerbate childhood sexual abuse issues.⁴⁸ They also discuss how retirement, perhaps with relocation away from support systems, can result in older female survivors having to spend more time with abusive husbands leading to a deterioration in their psychological health.⁴⁸ Hill describes how retirement resulted in further social isolation for a particularly disturbed older male survivor.⁶⁵

1.3.2.4 Life Review, Reminiscence, Rumination

As adults age they may come to question the meaning of their life. This may occur at an identifiable point in time, like turning 60, or over a period of time for instance following retirement or near the end of their life. Wadeson discusses an older male survivor who, when he turned 60, felt he had wasted his life and became more depressed.⁶⁹ This turning point propelled him to seek help and to explore his abusive childhood, which was ultimately healing for him.⁶⁹ In an example by Gagnon and Hersen, an older male survivor had worsening of his symptoms over the previous five years, was ruminating more about his childhood problems and felt an overwhelming need to atone for his sins, possibly because he was viewing his childhood through the *“critical and blaming eyes of a punitive adult”*.⁴⁸ For older adult survivors who sense the closeness of their death, reminiscence may make them realise the finality of the cost of their childhood sexual abuse. In the case described by McInnes-Dittrich this included a life of *“loneliness caused by the lack of a husband and children”*.⁵⁰ At this final stage in their lives, older adult survivors may simply not want to go to their graves without ever having told anyone about what was done to them.⁵¹

Table 1.3.2 In Older Age - Events, Timing, Transitions, Risk and Protection

Findings that make up this Category and Illustrations from the Texts

#	Finding	Illustration from Text
1	The residual effects of childhood sexual abuse, while not the result of advanced age, may be compounded by the losses that can occur in older age; like the loss of peer support and physical health, or the loss of roles and resources that may have distracted the younger survivor from unresolved abuse issues. [C]	"It is our belief that, for many elderly persons, these residual effects are not the result of advanced age but are lifelong in nature. What needs to be considered is the possibility that older adults may suffer continued, and possibly increased, difficulty coping with unresolved childhood sexual trauma. We suspect that these difficulties may be compounded because of the loss of peer support, physiological changes in later life, and the loss of roles and resources that at one time served to distract the survivor and alleviate the stress arising from unresolved abuse issues." (page 14)
1	The death of a spouse may be the life event that exacerbates the older female survivor's symptoms of unresolved childhood sexual abuse. [U]	"She also reported that her symptoms became more acute after her husband's death 6 years prior to therapy." (page 15)
4	The death of a spouse and related feelings of guilt about their intimate relationship; linked to childhood sexual abuse, may precipitate severe depression in older female survivors. [C]	"This woman had been unable to have a sexual relationship with her dearly loved husband and presented with depressive symptoms after his death." (page 268) "A predominant theme at the first interview was that, now that he had died, her husband could never forgive her for how badly she had treated him." (page 267)
7	Historical recollections of childhood, for instance of the 1918 flu epidemic, may reawaken traumatic childhood memories and lead to disclosure of sexual abuse. [U]	"... recollections of the flu epidemic of 1918 resurrect memories of the most grievous insults to the patient's health – abandonment by her mother and sexual abuse as a child." (page 228)
13	Older adult survivors may have increased vulnerabilities to unresolved childhood sexual abuse because of stress arising from major life events and transitions such as the loss of peer support, roles and resources. [C]	"Stress arising from major life tasks and transitional periods may overwhelm the coping abilities of CSA survivors, predisposing them to psychological distress.... there are several such factors that may increase older adults' vulnerability to unresolved CSA. Loss of peer support and loss of roles and resources have been suggested as potential stressors ..." (page 190)
13	A developmental task of old age e.g. life review, coupled with role loss; retirement, & discontinuation of maladaptive coping strategies; alcoholism, may exacerbate unresolved childhood sexual abuse. [C]	"This case exemplifies how a developmental task of old-age, life review, coupled with role loss (i.e. work) and discontinuation of maladaptive coping strategies (e.g. alcoholism) may exacerbate unresolved CSA." (page 196)
13	Older female survivors may become increasingly dysphoric if they lose contact with their support system with relocation and are forced to spend more time with an abusive, alcoholic husband. [U]	"When she lost frequent contact with this support system and was forced to spend most of her time with her verbally abusive alcoholic husband, she became increasingly dysphoric." (page 193)

13	Older adult survivors who have not dealt adequately with their abuse may find reminiscence, a developmental task of old age, may reopen psychic wounds. [C]	"Reminiscence is a normal task of old age that may heighten survivor's vulnerability to unresolved CSA. ...For survivors who may not have dealt adequately with their abuse or who have largely avoided even remembering such events, life review may reopen psychic wounds." (page 191)
13	Ageing male survivors may feel an overwhelming need to atone for perceived sins, possibly because they view their childhood through the critical eyes of a punitive adult. [C]	"Further, he admitted that, because he was growing older, he felt an overwhelming need to "atone" for his sins." (page 195) "Saul was evidently viewing his childhood behaviour through the critical and blaming eyes of a punitive adult, much like his father..." (page 195)
14	Adult survivors with cancer can react with fear, anger and withdrawal to both the extraordinary and mundane aspects of cancer treatment. [U]	"... survivors of CSA with cancer can react with fear, anger and withdrawal to both the extraordinary and mundane aspects of being treated for cancer." (page 125)
15	Older male survivors may experience social isolation following retirement. [U]	"Now he has retired from these pursuits he spends his time in his flat with his pet dog." (page 137)
16	Older female survivors may be more fixated on their childhood sexual abuse during later years, as they come to realise the finality of the impact the abuse has had on their life. [U]	"Ms B was unable to forget. In fact, she had fixated on the abuse more during her later years than she had earlier in life. She blamed her father for the loneliness caused by her lack of a husband and children." (page 170)
17	Older adult survivors can experience cancer as another trauma that can activate attachment insecurities and complicate treatment and the provision of palliative care. [C]	"For individuals with a history of trauma, cancer can be experienced as another trauma that activates attachment insecurities and can complicate cancer treatment and palliative care provision." (page 231)
19	After a defining event like the death of the perpetrator, older female survivors may begin to experience memories, for the first time, of their abuse. [U]	"Soon after that [the death of her father], Maria began to experience memories, for the first time, of being sexually assaulted during her teenage years by her father." (page 57)
20	Older female survivors; with realisation of the closeness of death, may not want to go to their graves without ever telling anyone what was done to them as a child. [U]	"... and I knew I did not want to go to my grave without ever telling anyone what was done to me". (page 109)
25	Older male survivors may seek therapy because they have reached a stage in life; e.g. turning 60, and are depressed feeling they have wasted their life. [U]	"He had sought therapy because he had just turned 60 and was depressed, feeling he had wasted his life." (page 100)
26	Feelings of grief and loss of control that are common as we age, may be similar to the emotions evoked during the abuse, resulting in re-emergence of painful childhood memories. [C]	"Grief and feelings of loss of control are common experiences as we age in our society. These may be similar to emotions evoked during the incestuous relationship, perhaps causing a resurgence of incestuous memories." (page 15)
26	Older adult survivors may have more time for reflection, as their roles change and they no longer have a busy schedule of child-rearing, careers and active relationships to provide distractions from their painful memories. [C]	"Roles change; no longer does the busy schedule of child-rearing, careers, and active relationships provide distractions from painful memories. There is much more time for reflection." (page 15)

Refers to the Paper or Text Number from **Master Table 1. The Master Table of Texts**, in Appendix I
[U] = Unequivocal – beyond reasonable doubt; [C] = Credible – plausible in light of the information



1.3.3 During Physical and/or Cognitive Decline

1.3.3.1 Critical Life Events – Physical Illness

Critical life events, such as physical illness, may precipitate disclosure of childhood sexual abuse with positive outcomes, like improvement in a chronic leg ulcer.⁶⁴ A cancer diagnosis and treatment however, may reactivate traumatic memories, even resulting in crisis situations when they emerge unexpectedly during care.^{49, 67}

1.3.3.2 The Transition into Dependency

Unresolved early traumas, even though buried deep in memory, may continue to affect behaviour and mental health, especially as older adult survivors become frail.⁵⁹ Gagnon and Hersen suggest that *“declining physical health and functional limitations are late-life stressors that may exacerbate unresolved CSA”*.⁴⁸ They propose that this may be the result of a heightened sense of hopelessness and/or helplessness caused by *“reawakened fears of interpersonal vulnerability, increased interpersonal dependence, and/or realization of a foreshortened future”*.⁴⁸

Allers and colleagues even suggest that unresolved early abuse issues may result in problems in older age that may threaten independence.⁴⁶ They illustrate this with the case of an older female survivor who presented with disorientation that was limiting her ability to function. Her dependency was subsequently resolved, when the negative impact of unresolved childhood sexual abuse on her current functioning, was understood and treated.⁴⁶ Allers and colleague propose that dissociation, a mechanism that allowed the child to cope with abuse at the time, but which in older adulthood is maladaptive, may present as disorientation wrongly suggesting the presence of dementia.⁴⁶ Dissociation may also result in behaviours that are seen as difficult in the care setting.⁵²

The text by Resnick-Cortes highlights what she sees as the essence of the loss experienced by physically frail older female survivors, the *“loss of a necessary defense mechanism, control of her memories”*.⁵⁵ When older female survivors must receive personal care that reactivates memories of their childhood sexual abuse, they can no longer suppress those memories because to some extent those memories are again real.

1.3.3.3 Dementia

Older adult survivors with dementia are at particular risk for distress as their awareness becomes more fragmentary and they become unable to regulate their feelings of being safe. If they do not feel safe then this may reawaken earlier periods in their life when they also felt unsafe, such as when they were sexually abused as a child.⁶⁰

As dementia progresses, past memories may become more intrusive and if unpleasant, distressing. Not only does the person with dementia feel unsafe, remember unpleasant past memories, but *“because of their cognitive deficits, they have no means of understanding, controlling or suppressing the psychic pain caused by these experiences”*.⁶⁰ Walter supports this when she suggests that *“...previously effective defense mechanisms may become faulty due to a decline in cognitive function”* so that older adult survivors may no longer be able to suppress their long-term memories of abuse.⁶³

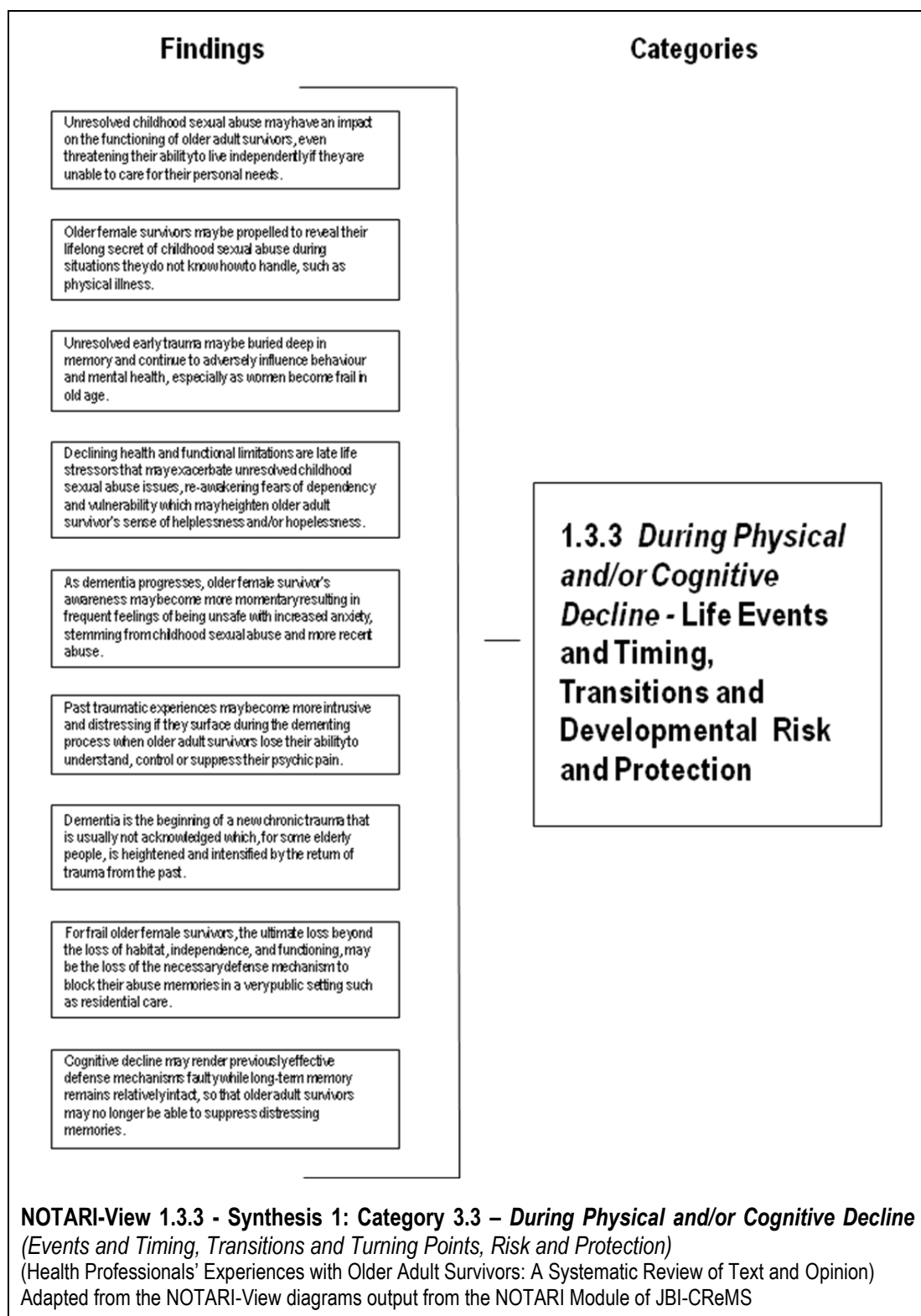
Meisen and Jones also see dementia as the beginning of a new chronic trauma which for the older adult survivor is *“heightened and intensified by the return of trauma from the past”*.⁶⁰

Table 1.3.3 During Physical or Cognitive Decline – Events, Timing, Transitions
Findings that make up this Category and Illustrations from the Texts

#	Finding	Illustration from Text
1	Unresolved childhood sexual abuse may have an impact on the functioning of older adult survivors, even threatening their ability to live independently if they are unable to care for their personal needs. [U]	“This case study illustrates the impact the unresolved childhood sexual trauma has on the functioning of an older adult. Specifically, the client’s disorientation and inability to care for her personal needs threatened her ability to live independently.” (page 15)
7	Older female survivors may be propelled to reveal their lifelong secret of childhood sexual abuse during situations they do not know how to handle, such as physical illness. [C]	“... nursing intervention often occurs at a time of chaos when people are in situations they do not know how to handle.... the physical illness (venous stasis ulcers) is the “critical event ... that propels [her] system into [chaos]” and subsequently, transition.” (page 228)
9	Unresolved early trauma may be buried deep in memory and continue to adversely influence behaviour and mental health, especially as women become frail in old age. [C]	“Such unresolved early traumas are often buried deep in memory but may continue to influence behaviour and mental health, especially as a woman becomes fragile and frail in old age.” (page 67)

13	Declining health and functional limitations are late life stressors that may exacerbate unresolved childhood sexual abuse issues, re-awakening fears of dependency and vulnerability which may heighten older adult survivor's sense of helplessness and/or hopelessness. [C]	"Declining physical health and functional limitations are other late-life stressors that may exacerbate unresolved CSA. Specifically, poor health may heighten a survivor's sense of helplessness and/or hopelessness via reawakened fears of interpersonal vulnerability, increased interpersonal dependence, and/or realization of a foreshortened future." (page 191)
18	As dementia progresses, older female survivor's awareness may become more momentary resulting in frequent feelings of being unsafe with increased anxiety, stemming from childhood sexual abuse and more recent abuse. [U]	"Her awareness context progressed from being continuous to only momentary. Thus her anxiety levels became raised as the momentary awareness context led to present feelings of being unsafe which went back to childhood, the sexual abuse she had suffered from her father and then later possibly also from her son." (page 150)
18	Past traumatic experiences may become more intrusive and distressing if they surface during the dementing process when older adult survivors lose their ability to understand, control or suppress their psychic pain. [C]	"The account illustrates how, over time, past experiences become more intrusive and distressing for her, surfacing at a time when her grasp of what was happening around her was becoming less secure." (page 144) "Because of their cognitive deficits, they have no means of understanding, controlling or suppressing the psychic pain caused by these experiences." (page 152)
18	Dementia is the beginning of a new chronic trauma that is usually not acknowledged which, for some elderly people, is heightened and intensified by the return of trauma from the past. [C]	"The tragedy is that the trauma of dementia is chronic and usually unacknowledged. It is our challenge to understand dementia syndrome as the beginning of a new chronic trauma which, for some elderly people, is heightened and intensified by the return of trauma from the past." (page 153)
21	For frail older female survivors, the ultimate loss beyond the loss of habitat, independence, and functioning, may be the loss of the necessary defense mechanism to block their abuse memories in a very public setting such as residential care. [C]	"Mrs M.'s loss of control was more than a loss of habitat, a loss of independence, and a loss of functioning. Her loss, was a loss of a necessary defense mechanism, control of her memories. In a public setting, she could no longer block the painful reoccurrences of her abuse." (page 77)
26	Cognitive decline may render previously effective defense mechanisms faulty while long-term memory remains relatively intact, so that older adult survivors may no longer be able to suppress distressing memories. [C]	"...as one ages, previously effective defense mechanisms may become faulty due to a decline in cognitive function. One may no longer be able to suppress memories and, unfortunately for the elderly incest survivor, it may be one's long-term memory that is left intact." (page 15)

Refers to the Paper or Text Number from **Master Table 1. The Master Table of Texts**, in Appendix I
[U] = Unequivocal – beyond reasonable doubt; [C] = Credible – plausible in light of the information



1.4 LINKED OR INTERDEPENDENT LIVES -The nature and quality of the connection to significant others and wider society

Individual lives are linked at all levels within and between families, generations, cultures and societies. These linkages can support, control or damage the individual or the larger unit. However, the family is the primary unit for experiencing and interpreting the life course and in most of the cases described in these texts, those early experiences have been damaging to the child, to the adult and to the older adult they have become. The older adult survivors represented have suffered initial damage and then later re-victimization, relationship problems and multi-generational problems. Forming and sustaining healthy relationships is perhaps the main challenge faced by survivors throughout their life course into older age, when loneliness can be felt intensely as other pursuits that have occupied their time may come to an end.

1.4.1 Close Interpersonal Relationships

Colarusso suggests that survivors may have difficulties with, or avoidance of, interpersonal relationships because of their “*expectations of rejection, betrayal, persecution or exploitation*” and that while they may engage in social activity, it may only be at a superficial level.⁴⁷ McLean and Hales argue that childhood physical and sexual abuse perpetrated by close attachment figures, may contaminate all close relationships because of resultant attachment disorders.⁶⁷ The 90 year old female survivor described by Capasso, had lived a reclusive life for the past twenty five years feeling let down and mistrustful,⁶⁴ while the older male survivor described by Hill, had never had a confiding relationship in his life.⁶⁵ Several of the older female survivors had never married^{50, 51, 55, 61, 66, 70} and may even have been required to care for their aging abuser or non-protective parent.^{62, 64}

1.4.2 Intimacy and Sexuality

Relationship difficulties may also have stemmed from problems with intimacy and sexuality that may be the consequence of childhood sexual abuse.^{43, 47, 56, 57} While these problems may have existed throughout adulthood, by the time survivors reach older age, many opportunities may have been lost to resolve the problems before the final loss by death of their partner, makes that impossible and complicates the grief process.⁴³

1.4.3 Re-Victimisation

Older female survivors may have experienced and tolerated various forms of abuse throughout their lives, even into old age, because of their low self-esteem.^{46, 48} Often the re-victimisation suffered by older female survivors occurred within their immediate family, at the hands of their spouse or even their children, and alcoholism was often implicated in the abuse.^{48, 60}

The very disturbed older female survivor described by Sarkar, engaged in prostitution, and experienced sexually and physically violent relationships in younger adulthood.⁶⁶ The older female survivor described by Gagnon and Hersen, tolerated physical, emotional and sexual abuse from her husband for many decades, because she could compartmentalise that part of her life while she enjoyed “a sense of personal validation, enjoyment, and temporary relief”⁴⁸ from her relationships with her children, grandchildren and friends. However, when she had to spend most of her time with him, without the support of her family, she came to realise that she had “married a monster”.⁴⁸ Even then, after two years of therapy, including cognitive behavioural therapy to improve her self-esteem, assertiveness training to manage her anger, while also learning self-protective strategies and developing a safety plan, she had not decided to leave her husband.⁴⁸

1.4.4 Multi-Generational Links and Consequences

Lives are also linked across generations. The original abuse may have occurred because the child was looking for “approval and affection”⁴⁸ from a parent unable to provide it because of their own issues. The “approval and affection” was then derived from abusive strangers.⁴⁸

The relationship between adult survivors and their parents may have always been distant if the parents were seen to be unable to protect them from the original abuse.⁴⁷ Several of the older female survivors came to attribute blame to their mothers for not protecting them from the abuse (Relational Table 1.2 The Abuse and Consequences).^{50, 55, 56, 62}

Adult survivors of any age may be required to provide practical care to the parents who abused or failed to protect them.⁶⁸ Capasso describes one older female survivor who cared for her adoptive parents, including the abuser, until they died at advanced ages, to the

detriment of her own intimate relationships.⁶⁴ If the survivor has to provide hands on personal care, like the older female survivor described by Altschuler and Katz, the stress can be particularly severe.⁶²

The current family life of older adult survivors may also be impacted by unresolved issues, possibly related to childhood sexual abuse. Wadeson discusses the mundane family life of one older male survivor who quarrelled frequently with his wife and saw his children as “spoiled rotten”.⁶⁹ The older female survivor described by Fakhoury and colleagues who was experiencing psychogenic seizures, lived in a family with significant turmoil including a son’s murder and an abusive husband.⁴⁵

1.4.5 Sibling Relationships

The importance of sibling relationships and support in the healing process, are discussed in several of the texts.^{50, 55, 64, 68} Siblings may only admit to each other that they were abused during therapy in later life, and only then come to support each other.^{50, 55} Moyer highlights the importance of sibling relationships in the healing process, but indicates that if these relationships are strained, perhaps because the only way to handle the “heavy secret” was to avoid emotional closeness, then it may take the death of the parents, especially the abuser, before the siblings can reconcile.⁶⁸

If the perpetrator was a sibling and the abuse lasted into adulthood, the older adult survivor may feel a complex mixture of fear and pleasure that can compound their guilt and depression.⁷⁰ Additionally, the sibling is more likely to still be alive and the older adult survivor may be fearful that the family will find out about the incestuous relationship.⁷⁰

1.4.6 The Abused as an Abuser

Survivors of childhood sexual abuse may also have become abusers of children. The paper by Hill concerns an older male survivor with severe psychological disorders and past alcohol abuse, who admitted to sexually abusing boys in his charge years before.⁶⁵ Gagnon and Hersen give the example of an older male survivor who felt guilt and remorse for having sexually abused his young sister when he was an adolescent, probably as the result of “hypersexuality and sexual acting-out” caused by his own abuse and victimisation by numerous male perpetrators.⁴⁸

The sentinel event that led to the older female survivor described by Sarkar, being incarcerated in a psychiatric facility for 30 years, was the severe physical abuse, attempted murder and neglect, of her infant child.⁶⁶

Table 1.4 Linked or Interdependent Lives

Findings that make up this Category and Illustrations from the Texts

#	Finding	Illustration from Text
1	Adult survivors frequently report tolerating abusive adult relationships because their childhood experiences left them with low self-esteem and feelings of worthlessness. [C]	"Adult survivors of unresolved abuse frequently report tolerating abusive adult relationships as a consequence of childhood experiences and as a result of very low self-esteem and feeling worthless or hopeless." (page 16)
3	Older female survivors may experience an exacerbation of the stress of caring for an elderly mother, who they feel did not protect them from abuse, when hands on personal care is required. [U]	"She was caring for her 89-year-old mother and it was becoming increasingly more difficult, as she had to provide hands-on-care. ...her stepfather had abused her from the time she was 3 years old, and her mother 'did nothing' to protect her." (page 206)
5	Relationship problems can stem from sexual problems, some of which are the consequence of childhood sexual abuse. [C]	"Many problems in a relationship have their roots in sexual dysfunctions Some of these sexual problems are the consequence of traumatic experiences in childhood and adolescence, such as sexual abuse within the family." (page 31)
5	Older female survivors may express some forgiveness for the perpetrator; usually the father, and instead come to blame their mother. [U]	"At the present time, for the most part she feels sorry for him and tends to blame her mother for having rejected him sexually." (page 34)
7	Older female survivors may have provided care for their parents, including the perpetrator, until the parents died at an advanced age. [U]	"She cared for her adoptive parents until they died at advanced ages while she continued to work for the investment division of an insurance company." (page 227)
8	Older adult survivors may have always had limited interpersonal relationships because of their expectations of rejection, betrayal, persecution or exploitation. [C]	"Interpersonal relationships tend to be very limited or completely avoided based on expectations of rejection, betrayal, persecution or exploitation." (page 329)
8	Older female survivors may have difficulty with sexual relationships and intimacy because they nearly always associate, consciously or unconsciously, sexual experiences with their childhood sexual abuse. [U]	"Anna does have sex with her husband but never really shares herself. 'Underneath it all I think sex is dirty.' She is relieved when her husband doesn't request sexual relations." (page 327) "Sexual experience was nearly always associated consciously and unconsciously with their encounters with Father C." (page 344)
8	Older female survivors of sexual abuse by the clergy may have felt that there was no safe place, not even the family home, resulting in distant relations with parents, and rejection of religion. [U]	"There was nowhere to turn, no one to help. There was no safe place, not even home. The eventual result was distant relations with their parents during adolescence and adulthood and a total rejection of Catholicism and to a lesser degree of a belief in God." (page 343-344)

9	Late-life unravelling of complex relationships that evolved out of the childhood sexual abuse may exacerbate unresolved symptoms and even precipitate suicidality. [U]	"... At age 69, she was referred for therapy after becoming suicidal when her husband [whom she married to escape her abusive father] became ill and it appeared that he might die before her 93-year-old father." (page 66)
11	Older female survivors abused by their brother well into adulthood, may have ambivalent feelings; including life-long fear combined with some sort of pleasure, which may have compounded their feelings of guilt and depression. [C]	"Another issue which was never verbalized was her degree of compliance: perhaps even some sort of pleasure combined with her life-long fear of her abuser [her brother], which compounded her feelings of guilt/depression." (page 48)
11	Older female survivors may still live in fear that their family will find out about an incestuous relationship that lasted into adulthood. [U]	"She still lives in fear that the family might somehow guess the relationship." (page 48)
11	Older female survivors may be socially isolated and unable to form close social ties.	"... most striking trait is isolation and inability to form close social ties." (page 47)
11	Older female survivors may be sociable but only at a safe superficial level. [U]	"She is a sociable person when she needs to be, and then only at a safe superficial level." (page 48)
12	Older female survivors may become symptomatic because of significant family turmoil. [C]	"Psychiatric consultation identified significant turmoil in the patient's family; her son had been murdered and she blamed the son's wife." (page 1050)
13	Older female survivors' positive relationships with children, grandchildren, and friends may have provided a sense of personal validation, enjoyment and temporary relief from their abusive marriages. [C]	"Clearly, the client's positive relationships with her children, grandchildren, and girlfriends had provided her with a sense of personal validation, enjoyment, and temporary relief from her abusive marriage." (page 193)
13	Older male survivors may only come to realise during therapy, that they initially derived a sense of acceptance from the men who sexually abused them as children, because they desperately wanted, but never received, approval and affection from their father. [U]	"Through his work with three therapists, two females and a male, Saul was able to realize that he desperately wanted approval and affection from his father, which he never received. Moreover, he noted that he initially derived a sense of acceptance from the men who sexually abused him." (page 195)
15	Older male survivors may have had severe lifelong relationship problems, never having a confiding relationship with anyone. [U]	"He has never had a confiding relationship with anyone ..." (page 137)
15	Older male survivors may disclose a history of sexual abuse of children in their care. [U]	"Mr X was admitted to an acute psychiatric hospital ... because he had been saying odd things to the warden of his flats, about abusing children and his dog. ... he claimed to have abused six boy scouts while he was a scout master about 20 years ago." (page 137)
16	Older female survivors may unconsciously project much of their anger toward their father onto their husband, whose behaviour may remind them of their abusive father. [C]	"Mrs L projected much of her anger toward her father onto her husband. She unconsciously developed dissociative behaviour in response to her husband's taunts, which reminded her of her father's teasing prior to an abusive incident." (page 169)

16	Older female survivors may not be able to allow others to provide care for their disabled children, because of fear that someone might take advantage of them sexually. [U]	"Mrs M was not afraid that others could not provide care, but rather that someone might take advantage of her daughter sexually. Her terror was so real that she had refused her own medical treatment." (page 169)
16	Unresolved abuse may have plagued older women and their relationships for decades, with spouses, children and extended family members directly or indirectly affected. [C]	"The unresolved abuse may have plagued the older woman and her relationships for many decades. Spouses, children, and extended family members may have all directly or indirectly felt the effects of the abuse." (page 170)
16	Older female survivors may only discover during therapy that their sisters had also been sexually abused in childhood and had not disclosed it even to each other. [U]	"Both sisters [of Ms B] had been abused by the grandfather as well and had not admitted it even to each other." (page 171)
17	All close relationships may be contaminated by childhood trauma, especially physical and/or sexual abuse perpetrated by close attachment figures. [C]	"In the case of couples where one is facing terminal cancer and they present with histories of childhood abuse, especially physical and/or sexual abuse most often perpetrated by close attachment figures, "all close relationships tend to be contaminated by the trauma." (page 228)
18	Older female survivors may suffer lifelong and extensive family relationship problems including re-victimisation and sexual aggression within their family. [U]	"Twelve other children were born during the marriage. Her (younger) daughters have always been frightened by the aggression and sexual advances of John. They describe him as less educated, aggressive and an alcoholic. John is suspected of sexual abuse and violence against his mother ..." (page 143)
19	In the older adult years there may be many role and power reversals as parents who may have abused or manipulated their children now need care from them. [U]	"Role and power reversals abound. The parents who loved and nurtured, or abused and manipulated them, now need help." (page 55)
19	Sometimes, especially in dysfunctional families of origin, both parents need to die before older adult siblings can reconcile with each other and form deeper relationships. [C]	"Sometimes, especially in dysfunctional families, both parents need to die before older adult siblings can begin to reconcile with each other." (page 56) "All in their 60s, Julio, Maria and Paulina experienced rather superficial relationships with each other until the death of their father, their remaining parent." (page 57)
19	Older adult siblings can be an important support for each other as they struggle to heal and process their shared childhood abuse experiences. [C]	"Older adult siblings can be very helpful to each other as they each struggle to heal and process their experience." (page 57)
19	Older adult siblings may have handled their part of the heavy incest secret by avoiding emotional closeness with each other for decades. [U]	"Each sibling had handled his or her part of this heavy secret by avoiding emotional closeness with each other." (page 57)
21	Siblings may only reveal their shared sexual abuse secret to each other in older adulthood. [U]	"She stated that her sister had also been sexually abused as a child and that recently both had revealed the details of that abuse to one another." (page 77)

23	Older female survivors may have had past dysfunctional relationships including suicide by a partner and re-victimisation with physical and sexual violence. [U]	"Her first romantic partner committed suicide Her second relationship was a sexually and physically violent one that resulted in an unplanned and unwanted pregnancy that she tried to self-abort ..." (page 304)
23	Older female survivors may have severely abused and neglected their own young child. [U]	"Her index offense involved severe abuse and neglect and attempts to kill her daughter." (page 304)
25	Older male survivors may have come from a dysfunctional family of origin with an alcoholic abusive father and a depressed, inaccessible mother. [U]	"His brothers had tormented him and abused him sexually as far back as he could remember. His father was an alcoholic who disappeared frequently and when home had angry tirades, beating everyone in the household. His mother was depressed and pretty inaccessible to him." (page 100)
25	Older male survivors may have ongoing relationship problems with their wife and children. [U]	"He quarrelled frequently with his wife and said that his two grown children were "spoiled rotten"." (page 100)

Refers to the Paper or Text Number from **Master Table 1. The Master Table of Texts**, in Appendix I
[U] = Unequivocal – beyond reasonable doubt; [C] = Credible – plausible in light of the information

Findings

Categories

Adult survivors frequently report tolerating abusive adult relationships because their childhood experiences left them with low self-esteem and feelings of worthlessness.

Older female survivors may experience an exacerbation of the stress of caring for an elderly mother, who they feel did not protect them from abuse, when hands on personal care is required.

Relationship problems can stem from sexual problems, some of which are the consequence of childhood sexual abuse.

Older female survivors may express some forgiveness for the perpetrator; usually the father, and instead come to blame their mother.

Older female survivors may have provided care for their parents, including the perpetrator, until the parents died at an advanced age.

Older adult survivors may have always had limited interpersonal relationships because of their expectations of rejection, betrayal, persecution or exploitation.

Older female survivors may have difficulty with sexual relationships and intimacy because they nearly always associate, consciously or unconsciously, sexual experiences with their childhood sexual abuse.

Older female survivors of sexual abuse by the clergy may have felt that there was no safe place, not even the family home, resulting in distant relations with parents, and rejection of religion.

Late-life unravelling of complex relationships that evolved out of the childhood sexual abuse may exacerbate unresolved symptoms and even precipitate suicidality.

Older female survivors abused by their brother well into adulthood, may have ambivalent feelings, including life-long fear combined with some sort of pleasure, which may have compounded their feelings of guilt and depression.

Older female survivors may still live in fear that their family will find out about an incestuous relationship that lasted into adulthood.

Older female survivors may be socially isolated and unable to form close social ties.

Older female survivors may be sociable but only at a safe superficial level.

Older female survivors may become symptomatic because of significant family turmoil.

Older female survivors' positive relationships with children, grandchildren, and friends may have provided a sense of personal validation, enjoyment and temporary relief from their abusive marriages.

Older male survivors may only come to realise during therapy, that they initially derived a sense of acceptance from the men who sexually abused them as children, because they desperately wanted, but never received, approval and affection from their father.

Older male survivors may have had severe lifelong relationship problems, never having a confiding relationship with anyone.

1.4 Linked or Interdependent Lives Part 1 of 2

Findings

Older male survivors may disclose a history of sexual abuse of children in their care.

Older female survivors may unconsciously project much of their anger toward their father onto their husband, whose behaviour may remind them of their abusive father.

Older female survivors may not be able to allow others to provide care for their disabled children, because of fear that someone might take advantage sexually.

Unresolved abuse may have plagued older women and relationships for decades, with spouses, children and extended family members directly or indirectly affected.

Older female survivors may only discover during therapy that their sisters had also been sexually abused in childhood and had not disclosed it even to each other.

All close relationships may be contaminated by childhood trauma, especially physical and/or sexual abuse perpetrated by close attachment figures.

Older female survivors may suffer lifelong and extensive family relationship problems including re-victimisation and sexual aggression within their family.

In the older adult years there may be many role and power reversals as parents who may have abused or manipulated their children now need care from them.

Sometimes, in dysfunctional families of origin, both parents need to die before older adult siblings can reconcile with each other and form deeper relationships.

Older adult siblings can be an important support for each other as they struggle to heal and process their shared childhood abuse experiences.

Older adult siblings may have handled their part of the heavy incest secret by avoiding emotional closeness with each other for decades.

Siblings may only reveal their shared sexual abuse secret to each other in older adulthood.

Older female survivors may have had past dysfunctional relationships including suicide by a partner and re-victimisation with physical and sexual violence.

Older female survivors may have severely abused and neglected their own young child.

Older male survivors may have come from a dysfunctional family of origin with an alcoholic abusive father and a depressed, inaccessible mother.

Older male survivors may have ongoing relationship problems with their wife and children.

Categories

1.4 Linked or Interdependent Lives Part 2 of 2

NOTARI-View 1.4 - Synthesis 1: Category 4 - *Linked or Interdependent Lives*

(Health Professionals' Experiences with Older Adult Survivors: A Systematic Review of Text and Opinion)

Adapted from the NOTARI-View diagrams output from the NOTARI Module of JBI-CReMS

1.5 HUMAN AGENCY TO MAKE CHOICES

The human agency to make choices may be constrained by the effects of childhood sexual abuse so that the choices made, while providing some control of psychic distress at the time, may come at a terrible cost, such as “escape” to a lifetime of spousal abuse, a lifetime without children or the strengthening of maladaptive coping mechanisms such as substance abuse, self-harm, denial and dissociation. To some extent, control is an important aspect of the psychological coping mechanisms of the survivor at all stages of their life course. However, this control may have terrible consequences for the direction that their lives take.

1.5.1 *The Choice to Control ‘Pain’*

Colarusso describes the sisters sexually abused in childhood by their parish priest who all came to the conclusion that *“despite their heightened sense of awareness of the potential danger of predators, it was better to avoid having children, and girls, in particular, at all costs”*.⁴⁷ Anna, the oldest sister, made the deliberate choice not to have children.⁴⁷ Gagnon and Hersen talk of the woman who purposefully forgot the memory of her abuse for years.⁴⁸

Even deliberate self-harm may be a choice of sorts that gives the survivor some control over their psychological pain. The older female survivor, described by Sarkar, who repetitively harmed herself, paradoxically could not tolerate the pain of a physical illness.⁶⁶ Sarkar postulates that this was due to her lack of control over the pain which caused *“greater distress than the pain itself”*.⁶⁶

1.5.2 *The Choice to Maintain Defences*

The choice to deny the abuse may be the final choice that older adult survivors make and that may have to be respected by health professionals.^{50, 55} McInnes-Dittrich suggests that the final resolution of the abuse may be denial, because the defense mechanisms are also the coping mechanisms.⁵⁰ Resnick-Cortes also supports the right of older adult survivors to deal with their abuse issues to whatever degree they find comfortable, even if this means they refuse therapy.⁵⁵

1.5.3 The Choice to be Courageous

However, the resilience of older adult survivors can also result in them making courageous choices that can extract a considerable emotional toll. Anna, the older female survivor assessed by Colarusso for a legal case brought against the Catholic Church, was “determined to see justice done” even though she found the unfolding of the legal process very painful.⁴⁷

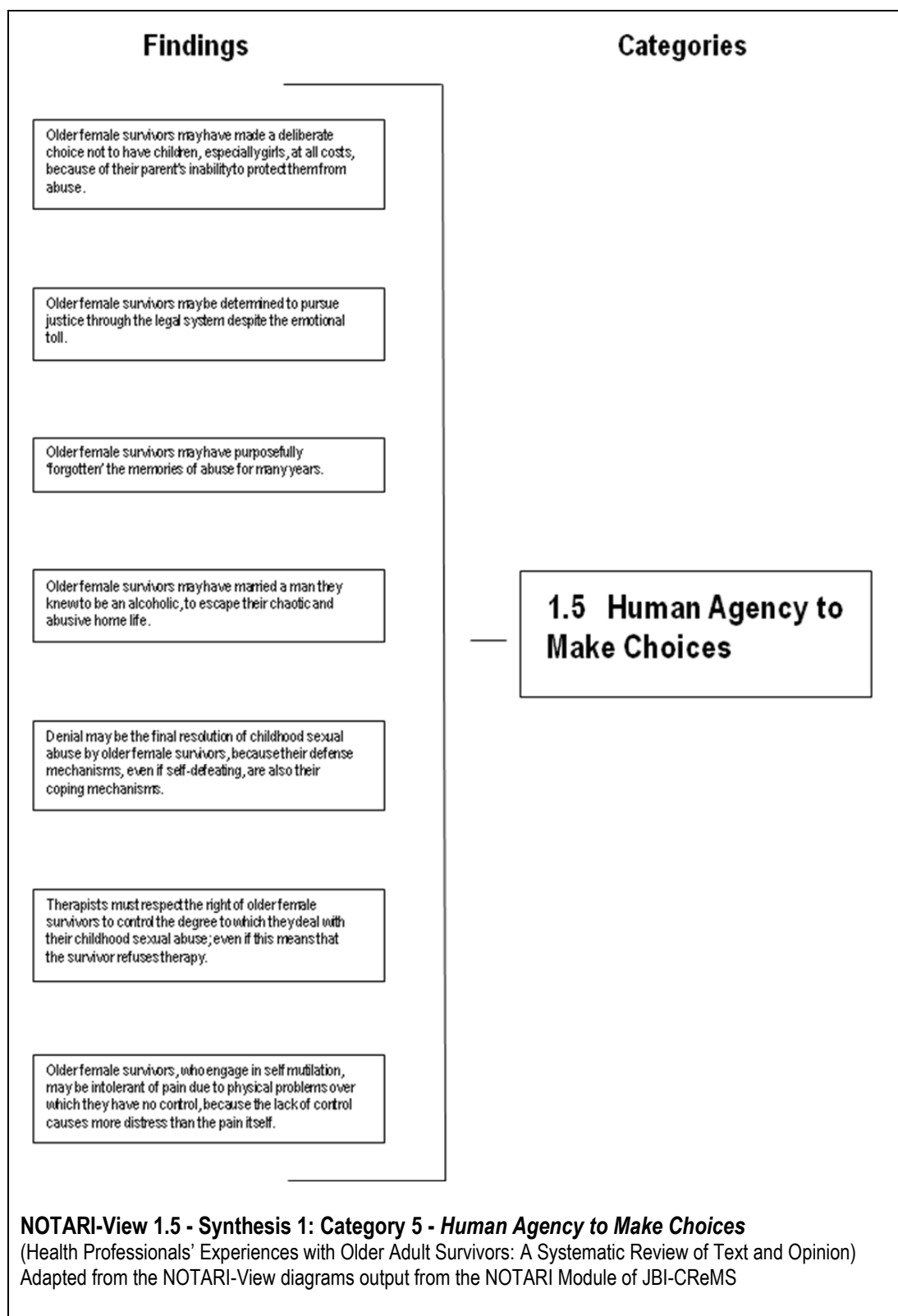
Table 1.5 Human Agency to Make Choices

Findings that make up this Category and Illustrations from the Texts

#	Finding	Illustration from Text
8	Older female survivors may have made a deliberate choice not to have children, especially girls, at all costs, because of their parent’s inability to protect them from abuse. [U]	“A further consequence of the parent’s failure to protect their children led to the conclusion on the part of all four that despite their heightened sense of awareness of the potential danger of predators, it was better to avoid having children, and girls, in particular, at all costs.” (page 344)
8	Older female survivors may be determined to pursue justice through the legal system despite the emotional toll. [U]	“Recent years have been painful as the legal process unfolded, exacting a great emotional toll on Anna. Despite her pain, Anna is determined to see justice done.” (page 328)
13	Older female survivors may have purposefully ‘forgotten’ the memories of abuse for many years. [U]	“Mary informed the psychotherapist that she had purposefully “forgotten” this memory for many years ...” (page 192)
13	Older female survivors may have married a man they knew to be an alcoholic, to escape their chaotic and abusive home life. [U]	“To escape her chaotic and abusive home life, Mary reported that she married her husband even though she knew he was an alcoholic.” (page 192)
16	Denial may be the final resolution of childhood sexual abuse by older female survivors, because their defense mechanisms, even if self-defeating, are also their coping mechanisms. [C]	“Even though it appeared as though Mrs L had processed the abuse thoroughly enough to release many self-defeating mechanisms, her final resolution of the abuse involved denial. Her defense mechanisms were also her coping mechanisms.” (page 169)
21	Therapists must respect the right of older female survivors to control the degree to which they deal with their childhood sexual abuse; even if this means that the survivor refuses therapy. [C]	“I respect her right to deal with the issues of childhood sexual abuse to whatever degree she finds comfortable.” (page 78)
23	Older female survivors, who engage in self mutilation, may be intolerant of pain due to physical problems over which they have no control, because the lack of control causes more distress than the pain itself. [C]	“Her intolerance of pain due to physical problems (given her highly raised pain threshold due to years of serious self-mutilation) was due to the lack of control over pain that causes greater distress than the pain itself, highlighting the impact of emotions on pain perception.” (page 309)

Refers to the Paper or Text Number from **Master Table 1. The Master Table of Texts**, in Appendix I

[U] = Unequivocal – beyond reasonable doubt; [C] = Credible – plausible in light of the information



1.6 DIVERSE AND INTERACTING LIFE COURSE TRAJECTORIES

The life course trajectories for each of these 38 older adults sexually abused as children are unique, dynamic and to some extent damaged. That damage started more than 50 years ago in a family of origin and a society where sexual abuse of a child could occur in profound silence. The damage has evolved across a life course where the older adult survivor has experienced interpersonal and social change, all the while accumulating risk and/or protective factors into their old age, where new challenges await.

1.6.1 Relational Trajectories

The texts included in this Systematic Review reveal the multiple interacting life course trajectories of many of these older adult survivors who are “*continuing to battle the residual effects of the abuse into old age*”.⁴⁶ Relational trajectories were perhaps the most damaged and consequently damaging to other aspects of their lives. One woman who had been sexually abused by her father in early life “*blamed that for the death of her child; the abusive first marriage and her inability to have a sexual relationship with her second husband*” who had now died making it impossible for her to make things right.⁴³

1.6.2 Trajectories of Marriage and Children

Several of the older female survivors were physically damaged by the abuse to the extent that they were unable to have children,^{43, 50, 55} while yet other women became psychologically “infertile”; making a conscious decision not to have children, especially female children who might also be abused.⁴⁷ While one woman suffered a “*lifetime of rage*” because of her abuse and resultant infertility,⁵⁰ another woman who was “*shattered*” by her infertility, transcended this by adopting children.⁵⁵

Early or imposed marriage to escape the abusive family of origin, often resulted in a lifetime of unhappiness, depression, and/or re-victimisation, usually at the hands of their husbands.^{43, 45, 46, 48, 50, 52, 55, 56, 58-60, 66} However, despite living in an abusive relationship for decades, older female survivors may have been able to create a family of children, grandchildren and friends around them that provided “*... a sense of personal validation, enjoyment, and temporary relief*”.⁴⁸

1.6.3 Trajectories of Inadequacy, Shame and Mistrust

Several of the older adult survivors had worked hard to achieve successful careers, but their low self-esteem was such, that they still felt they were *“not acceptable”* or *“rotten to the core”*.^{47, 69} One older female survivor appeared *“more troubled by self-doubt and feelings of inadequacy than is apparent to others”*,⁴⁷ while another revealed *“a lifelong pattern of disconnection, distrust and pain”*.⁶¹ Many had trouble with issues of trust. Wadeson states that survivors *“often feel shame and guilt, growing up with such feelings, in addition to finding it difficult to trust others”*.⁶⁹

1.6.4 Behavioural Trajectories

The behavioural life course trajectories of some of these older adult survivors were affected by substance abuse issues; including alcohol and prescription drug misuse.^{48, 51, 58} Additionally, negative body image issues,^{51, 62} repetitive self harm,^{50, 66} and suicidal ideation,^{43, 47, 48, 50, 51, 55, 59, 67, 70} were a substantial part of the life courses for many of these older adult survivors.

1.6.5 Trajectories of Silence

These texts also call attention to the trajectories of silence that were experienced to varying degrees by most of these older adult survivors. Sutton states that many of the survivors have *“... suffered alone in silence, confusion and fear for much of their lives”*.⁵² Sutton adds that *“it is important to have some grasp of what people endure in trauma over time; what they had to do to survive(literally and psychologically) and what it is like living in the aftermath, experiencing the silence of others and society”*.⁵² The 90 year old female survivor described by Capasso, avoided telling anyone about her abuse, even in *“deep analysis”*, for more than 80 years.⁶⁴

Croese probably sums up the essence of survival for the older female survivors when she says that *“though many older women may seem frail, they have survived into old age as women in a sexist society that is ripe with sexual assault and exploitation, resulting in many older women with histories of rape, incest, molestation, prostitution, abortion, or other sexually related traumas”*.⁵⁹ The diverse and interacting pathways that make up the long life courses of these older adult survivors, have at their heart the resilience of the survivor to

cope with and even transcend their abuse related problems, over and over again; together with a measure of good luck.

Table 1.6 **Diverse and Interacting Life Course Trajectories**

Findings that make up this Category and Illustrations from the Texts

#	Finding	Illustration from Text
1	Older adults who were sexually abused as children may continue to battle the residual effects of the abuse, including chronic depression and re-victimisation, into old age. [C]	"The authors of this study have worked with older adults who were sexually abused during childhood and have observed these clients continuing to battle the residual effects of the abuse into old age. These residual effects commonly appear in the form of chronic depression and revictimization (i.e., elder abuse) and may be misdiagnosed as dementia or mental illness." (page 14)
4	Childhood sexual abuse may have serious repercussions across the lifespan, including the inability to have children, abusive intimate relationships and sexual dysfunction that resonate into old age. [U]	"It emerged that she (along with several sisters) had been sexually abused by her father in early life and blamed that for the death of her child; the abusive first marriage and her inability to have a sexual relationship with her second husband". (page 268)
7	Older female survivors may reveal a lifelong pattern of disconnection, distrust, and pain emerging out of their childhood abandonment and abuse. [U]	"...resurrect memories of the most grievous insults to the patient's health – abandonment by her mother and sexual abuse as a child. Revelation of a lifelong pattern of disconnection, distrust, and pain follows." (page 228)
8	Older female survivors may have had a successful working life, but despite this success, may discount their achievements and continue to believe they are not acceptable. [U]	"During these years Anna continued to work and receive frequent promotions. Despite this success, she always worried that she was not acceptable." (page 328)
8	Older female survivors may present as having done well in life, but may be more troubled by self-doubt and feelings of inadequacy than is apparent. [U]	"Although generally appropriate, she is a high strung individual who tends to do well despite her insecurities.... She is more troubled by self-doubt and feelings of inadequacy than is apparent to others." (page 334)
9	Though many older women may seem frail, they have survived into old age despite a sexist society rife with sexual assault and exploitation, resulting in many older women with histories of early sexual trauma. [U]	"Though many older women may seem fragile and frail, they have survived into old age as women in a sexist society that is ripe with sexual assault and exploitation, resulting in many older women with histories of rape, incest, molestation, prostitution, abortion, or other sexually related traumas." (page 66)
9	Lifelong depression may be the price that older female survivors pay for marrying young, without love, to escape sexual abuse. [C]	"The price she paid [marrying young without love to escape abuse] was lifelong depression." (page 66)
11	Older female survivors may be very intelligent with qualifications that do not seem to give them any sense of lifetime achievement. [U]	"She is extremely intelligent, holding two masters' degrees (which does not seem to give her any sense of achievement)." (page 48)

13	Older female survivors may report that they have been “unhappy” for most of their life. [U]	“She reported that she had been “unhappy” most of her life and recalled a severe depressive reaction to her middle son’s death 23 years earlier.” (page 191)
13	Older female survivors may have suffered physical, verbal and sexual abuse by their alcoholic husband throughout most of their married life. [U]	“Mary also stated that her alcoholic husband of 41 years had abused her physically, verbally, and sexually throughout most of their marriage.” (page 192)
14	Older adult survivors may have suffered alone in silence and fear for most of their lives with their emotional resilience now tested by the added burden of a cancer diagnosis and the urgency of treatment. [C]	“They have all suffered alone in silence, confusion and fear for much of their lives. The added burden of a cancer diagnosis and the urgency of treatment tested their emotional resilience.” (page 127 Authors’ Note)
15	Older male survivors may have a long psychiatric history with severe depression complicated by alcohol abuse. [U]	“Mr X was admitted to an acute psychiatric hospital three times between 1979 and 1981 with severe depressive episodes complicated by alcohol. These depressive episodes had a psychotic component congruent with the depression.” (page 137)
16	Older female survivors may have suffered a lifetime of disappointment because of infertility caused by severe sexual abuse in childhood. [U]	“Her abuse was so severe that she was infertile, a source of deep disappointment to her.” (page 170)
16	A lifetime of rage because of the severe consequences of sexual abuse, such as infertility, may leave older female survivors bitter, depressed and agitated. [U]	“A lifetime of rage [severe CSA had left her infertile] had left her bitter, depressed, and agitated.” (page 170)
16	Even when childhood sexual abuse is common in a particular community, the emotional damage to older female survivors may still be devastating 60 years after the event. [C]	“... experience with these women points to the fact that despite the widespread occurrence of childhood sexual abuse in their communities, the emotional damage inflicted by the abuse was still devastating 60 years after the event.” (page 172)
20	Older female survivors may have abused substances such as alcohol to numb the memories of their childhood sexual abuse. [C]	“Veronica turned to alcohol to numb the memories of childhood sexual abuse she had experienced.” (page 106)
21	Older female survivors of childhood sexual abuse have lived full lives that have taken them beyond the abuse, because of their resilience. [C]	“Survivors must be reminded that they have indeed survived as a result of inner strength and fortitude. They must also be reminded that who they were [victims] is not who they are. These older women have lived full lives that have taken them way beyond their abuse.” (page 79)
21	Older female survivors may have been left infertile because of very early childhood sexual abuse but may have transcended their shattered dreams to some extent by other means, such as adopting children. [U]	“Mrs.S.’s dreams of giving birth were shattered through the early violation of her body, yet she made the children of others her own, adopting her three daughters.” (page 77)
24	It is important for health professionals to have some awareness of what older adult survivors have had to endure to survive (literally and psychologically) as they have lived in the aftermath of their trauma, experiencing the silence of others and of society. [C]	“It is therefore important to have some grasp of what people endure in trauma over time; what they had to do to survive (literally and psychologically) and what it is like living in the aftermath, experiencing the silence of others and of society.” (page 168)

25	Survivors of childhood sexual abuse often feel shame and guilt, growing up with such feelings and finding it difficult to trust others. [C]	"As a result, survivors of childhood abuse often feel shame and guilt, growing up with such feelings, in addition to finding it difficult to trust others." (page 99)
25	Older male survivors may feel that they have always been depressed. [U]	"He had always been depressed, he said." (page 100)
25	Older male survivors, because of their painful past and low self-esteem, may be driven to prove themselves as a successful businessman to gain some measure of self respect. [C]	"Mike was a distrustful man who had gained some measure of self respect through hard work and craftiness so that he was recognized in his community as a successful businessman. His painful past and low self-esteem that grew out of his childhood abuse led to a driven approach to his life that pushed him to prove himself." (page 103)
25	Despite the outward appearance of success older male survivors may still feel that their real self is "rotten to the core". [U]	"He said that although lots of people considered him a successful man, he knew he was "rotten to the core". (page 100)
26	Older adult survivors need to understand the strengths that have enabled them to survive a long life, and to differentiate between what happened in childhood and their life now. [C]	"Finally, one needs to stress to the patient that that was then and this is now. They have survived." (page 16)

Refers to the Paper or Text Number from **Master Table 1. The Master Table of Texts**, in Appendix I
[U] = Unequivocal – beyond reasonable doubt; [C] = Credible – plausible in light of the information

Findings

Older adults who were sexually abused as children may continue to battle the residual effects of the abuse, including chronic depression and re-victimisation, into old age.

Childhood sexual abuse may have serious repercussions across the lifespan; the inability to have children, abusive intimate relationships and sexual dysfunction, that resonate into old age.

Older female survivors may reveal a lifelong pattern of disconnection, distrust, and pain emerging out of their childhood abandonment and abuse.

Older female survivors may have had a successful working life, but despite this success, may discount their achievements and continue to believe they are not acceptable.

Older female survivors may present as having done well in life, but maybe more troubled by self-doubt and feelings of inadequacy than is apparent.

Though many older women may seem frail, they have survived into old age despite a sexist society rife with sexual assault and exploitation, resulting in many older women with histories of early sexual trauma.

Lifelong depression may be the price that older female survivors pay for marrying young, without love, to escape sexual abuse.

Older female survivors may be very intelligent with qualifications that do not seem to give them any sense of lifetime achievement.

Older female survivors may report that they have been "unhappy" for most of their life.

Older female survivors may have suffered physical, verbal and sexual abuse by their alcoholic husband throughout most of their married life.

Older adult survivors may have suffered alone in silence and fear for most of their lives with their emotional resilience now tested by the added burden of a cancer diagnosis and the urgency of treatment.

Older male survivors may have a long psychiatric history with severe depression complicated by alcohol abuse.

Categories

1.6 Diverse and Interacting Life Course Trajectories Part 1 of 2

Findings

Older female survivors may have suffered a lifetime of disappointment because of infertility caused by severe sexual abuse in childhood.

A lifetime of rage because of the severe consequences of sexual abuse, such as infertility, may leave older female survivors bitter, depressed and agitated.

Even when childhood sexual abuse is common in a particular community, the emotional damage to older female survivors may still be devastating 60 years after the event.

Older female survivors may have abused substances such as alcohol to numb the memories of their childhood sexual abuse.

Older female survivors of childhood sexual abuse have lived full lives that have taken them beyond the abuse, because of their resilience.

Older female survivors may have been left infertile because of very early childhood sexual abuse but may have transcended their shattered dreams to some extent by other means, such as adopting children.

It is important for health professionals to have some awareness of what older adult survivors have had to endure to survive (literally and psychologically) as they have lived in the aftermath of their trauma, experiencing the silence of others and of society.

Survivors of childhood sexual abuse often feel shame and guilt, growing up with such feelings and finding it difficult to trust others.

Older male survivors may feel that they have always been depressed.

Older male survivors, because of their painful past and low self-esteem, may be driven to prove themselves as a successful businessman to gain some measure of self respect.

Despite the outward appearance of success older male survivors may still feel that their real self is "rotten to the core".

Older adult survivors need to understand the strengths that have enabled them to survive a long life, and to differentiate between what happened in childhood and their life now.

Categories

1.6 Diverse and Interacting Life Course Trajectories Part 2 of 2

NOTARI-View 1.6 - Synthesis 1: Category 6 - Diverse Life Course Trajectories

(Health Professionals' Experiences with Older Adult Survivors: A Systematic Review of Text and Opinion)

Adapted from the NOTARI-View diagrams output from the NOTARI Module of JBI-CReMS

The Second Synthesised Finding *Acting on Understanding*

The basic theme of the Second Synthesised Finding is that health professionals should use their understanding of the context of their older clients' lives; which may include sexual abuse during childhood, to identify survivors and then to guide care within an optimised professional therapeutic alliance based on safety for both the older adult and the health professionals.

Central to the Second Synthesised Finding is the need for health professionals to act on the integrated, holistic understanding they should have gained about their older adult clients, who may be survivors of childhood sexual abuse. This action should occur within a therapeutic alliance where the older adult survivor and the health professional both feel safe to explore the possibilities for healing in an individualised, flexible and optimised way, based on evidence and best-practice.

As well as experience and skills, health professionals also need self-awareness, and the appropriate values and attitudes that will propel them to act, to help their older clients who may be suffering from unresolved issue, possibly related to earlier life experiences.

This Second Synthesised Finding provides a general approach to therapeutic action based on a theoretical framework that has evolved out of the relevant 194 themes and conclusions from the 26 texts, with reference to the extant literature. The Second Synthesised Finding has at its heart the First Synthesised Finding, that is, understanding the older adult survivor over their life course so that context can guide care.

However, the Second Synthesised Finding is of no consequence if societies, including health professionals and policy makers, believe that it is too late or too expensive to help older adult survivors to heal. The 26 texts in this systematic review describe older adult survivors, some with extremely difficult behavioural problems, whose quality of life has been improved by caring, innovative health professionals (Relational Table 1.6 the Outcome of Interventions, in Appendix I). These older adult survivors show that it is never too late for some degree of healing; even for the very old, the dementing or the dying, and that experienced and aware health professionals can safely 'open Pandora's Box'; if they have the will and support to do so.

The Conceptual Framework for the Second Synthesised Finding

The Second Synthesised Finding is made up of six major categories that have been interpretatively aggregated from 194 of the findings identified in the 26 texts. The six categories; while having evolved out of the texts are framed and enriched to a greater or lesser extent with reference to the extant literature. However, unlike the First Synthesised Finding, the conceptual framework for the Second Synthesised Finding is not augmented by an existing, more unified theoretical construct like the Life Course Perspective.

The first category is concerned with safety; both physical and psychological, because establishing and maintaining safety is a requirement of any therapeutic relationships and is usually the primary consideration of any manualised therapeutic intervention. The excellent, *"Handbook on Sensitive Practice for Health Care Practitioners: Lessons from Adult Survivors of Childhood Sexual Abuse"* by Schacter and colleagues, uses the metaphor of an overarching umbrella of safety.³⁹ However, safety for health professionals is also highlighted in many of the review texts, and this has been included as a second theme in this first major category.

Another major category, concerned with the experience and skills of health professionals has been augmented to take into account how values and attitudes can interact with skills to affect care. McGregor and colleagues, after reviewing the literature on training for health professionals concluded that *"it is not that HPs (health professionals) lack knowledge on CSA; they simply fail to put it into practice, feeling that such inquiries might be perceived as invasive or that they are unprepared to deal with the disclosure"*.⁷¹ The conclusions of Warne and McAndrew⁷² while based on mental health nursing practice, endorse this tension between knowledge, training and entrenched attitudes. They argue that there is a need for preparedness in two ways: through skills and knowledge and values and attitudes. However, they also highlight a potential problem of education, whereby *"current educational practices provide a sense of ontological security rather than enabling the individual to more effectively deal with turbulence and insecurity"*.⁷²

Mammen suggests that there is *"no single correct technique or model for working with survivors' abuse-related issues"* but she does suggest that there are certain principles appropriate to this work that can inform care.⁷³ This concept has been incorporated into the structure of the fourth category about therapeutic management.

The six major categories that make up the Second Synthesised Finding, and that have evolved out of the texts with reference to the extant literature as described above, are, like those categories in the First Synthesised Finding, dynamic rather than distinct categories that influence and interact with each other to provide a framework for therapeutic action.

The six major categories include:

- 2.1 Overarching Safety: For Older Adult Survivors and their Health Professionals
- 2.2 Health Professionals' Expertise & Knowledge, Self-Awareness, and Values & Attitudes
- 2.3 Identification and Disclosure Issues
- 2.4 Principles of Therapeutic Management: Dynamically Matching Goals to Needs
- 2.5 Optimised Therapeutic Interventions: Adapting, Innovating, Experimenting
- 2.6 Research: Evidence to Guide Practice

2.1 OVERARCHING SAFETY FOR OLDER ADULT SURVIVORS AND THEIR HEALTH PROFESSIONALS

The overarching theme of the second synthesised finding is the need for the interaction between older adult survivors and health professionals; be it at a primary level of care or at a specialist mental health level, to be conducted in an environment of physical and psychological safety.

2.1.1 Safety for Older Adult Survivors

2.1.1.1 Physical and Emotional Safety

Health professionals have a duty of care to consider the physical safety of their older adult clients. Gallo-Silver and Weiner state that survivors with acute symptoms of depression such as suicidal ideation or self harm, that may emerge during physical treatments; in this case for cancer, require *“psychiatric intervention that takes precedence over treatment ... until the patient can be stabilized with medication”*.⁴⁹

Health professionals also need to create a sense of safety, addressing the need for older adult survivors to contain intense emotion and distressing thoughts, such as flashbacks, by helping them to learn more adaptive ways of self-comforting.⁴⁹ Caution may also be needed in the pacing of disclosure of the abuse for older adult survivors because they may be slower than younger survivors to confront the terror of the abuse and they may be physically frail.⁵⁰

2.1.1.2 Respect

Sutton contends that the foundation of work with older adult survivors is to respect their wisdom, ego-integrity and self-worth even though they may be afraid and in despair, or as she states *“strong at the broken places”*.⁵²

2.1.1.3 Trust through Rapport

While trust is a necessary condition for safety, older adult survivors may have extreme difficulty developing trust with anyone.⁴⁶ Resnick-Cortes provides the example of an older female survivor that she worked with, who still had difficulty developing trust after three years.⁵⁵ To be able to trust, older adult survivors also have to feel that they are not being

judged and consequently rejected.⁴⁷ Colarusso sees this occurring within an *“empathetic, real relationship with the therapist”*.⁴⁷ Capasso similarly sees trust evolving out of a relationship built on *“rapport through caring, honesty and support”* which allows the older adult survivor to be vulnerable in a *“safe place”*.⁶⁴

2.1.1.4 Transparency

Therapeutic processes that are transparent can also build trust. Gallo-Silver and Weiner argue that transparency resulting from the explanation of interventions is *“crucial to helping survivors of childhood sexual abuse with cancer to reality test their distortions/misperceptions of the health care/psychosocial clinicians’ intentions and motivations”*.⁴⁹ If older adult survivors do not trust the intentions and motivations of health professionals then they will not engage fully in treatment be it for cancer, or for psychological issues arising from their abuse. Sarkar maintains that *“no change in humans, however achieved, is sustainable, unless it is meaningful to the person”*⁶⁶ so it is important not only for the survivor to understand the underlying meaning of the therapeutic interactions, but for health professionals to understand what meaning the survivor attaches to those interactions.

2.1.1.5 Empowerment

Empowerment is another aspect of safety that is important to older adult survivors. This may involve their ability to exercise choice, which, according to Gallo-Silver and Weiner is more than just consent, but the *“ability to be in control and explore options or alternative actions”*.⁴⁹ McInnes-Dittrich argues that true empowerment of the older female survivor may *“lie in the therapists’ respecting their conscious choice not to revisit the abuse”*.⁵⁰ Sutton and Walter emphasise the importance of the ability of the older adult survivor to have as much control as possible.^{52, 63}

2.1.1.6 Information and Communication

Health professionals need to be able to communicate information about the consequences of childhood sexual abuse that older adult survivors can relate to. This communication can strengthen the therapeutic bond and make survivors feel that they are no longer alone.⁵⁵ Education of older adult survivors can help them to *“understand how abuse contributes to decreased coping capacities, which in turn lead to experiences of low self-esteem”*.⁵¹

Table 2.1.1 Safety for the Older Adult Survivors*Findings that make up this Category and Illustrations from the Texts*

#	Finding	Illustration from Text
1	Older female survivors may be hesitant to discuss any part of their life with the therapist because of uncertainty as to whom they can trust. [U]	"Initially, the client was hesitant to discuss any part of her life with the therapist because she said she 'never knew who she could trust'..... The client's long history of abusive relationships and her uncertainty as to whom she could trust prevented her from initially reporting the assault." (page 16)
2	Therapists need the professional training to provide accurate information in an environment where the client feels they have permission to reveal their fears, desires and sexual concerns. [C]	"Without permission [to reveal] and accurate information [professional training], therapists and clients will collude in such feelings as fear, shame, disgust, guilt and frustration." (page 66)
7	Exploration and healing is facilitated when the ongoing therapeutic relationship provides a safe place for the survivor to be vulnerable. [C]	"The CNS has created a safe place for the patient to be vulnerable. An ongoing relationship between the CNS and the patient could help the patient to further explore patterns of interaction in her life and, potentially, transform and transcend her lifelong patterns of trauma and disconnection." (page 229)
7	The therapeutic relationship is built on a rapport of caring, honesty and support. [C]	"The memory is shared in the context of an environment in which the CNS builds a rapport through caring, honesty and support." (page 228)
8	Initially, treatment should be based on an empathetic, real relationship with the therapist so that older adult survivors do not feel judged and rejected. [C]	"Particularly during the beginning stages of treatment, I think these women will need an empathetic, real relationship with the therapist; analytic reticence, relative silence, and lack of face-to-face contact could be too depriving and increase anxiety and feelings of being judged and rejected." (page 347)
11	The therapist may have to put in place measures such as regular phone contact if the older female survivor has expressed suicidal ideation.[U]	"Following this disclosure I did not see her on regular days for about a week and a half. I made a point of calling her and asking how she was ...(I called her daily because she told me that she kept some medication stashed "in case I want to check out, you know?)" (page 49)
14	Psychosocial interventions should address adult survivors' (with cancer) need to feel safe during cancer treatment, to contain intense feelings and distressing thoughts and to acquire more adaptive ways of self-comforting. [C]	"Psychosocial interventions address the CSA survivor's needs for assistance in containing intense affect and distressing thoughts, acquiring more adaptive ways of self-comfort when experiencing flashbacks/body memory, and creating a sense of safety during the treatment experience." (page 118)
14	Acute symptoms of depression, including suicidal behaviour or self harm, require psychiatric intervention that takes precedence over cancer treatment, until the patient can be stabilised with medication.[C]	"Such acute symptoms of depression [suicidal and/or self injuring behaviours] require psychiatric intervention that takes precedence over the treatment of cancer until the patient can be stabilized with medication." (page 118)

14	The ability to exercise choice; a broader concept than just consent, is the key element in helping survivors with cancer to feel safe, to be in control, to explore options and to pace the introduction of new treatments. [C]	"For the survivors of CSA in the sample of convenience; the ability to exercise choice was the key element in helping them feel safe. ... "Choice" as a concept can be seen as a broader term than consent ... Within a counselling situation, "choice" addresses the CSA survivor's ability to be in control and explore options or alternative actions in an effort to pace the introduction of new treatments/procedures." (page 123)
14	Because childhood sexual abuse is such a profound boundary violation, it is important to maintain professional boundaries to create a safe environment for both survivor and health professional. [C]	"Childhood sexual abuse is considered a profound boundary violation....The maintenance of professional boundaries contributes to the creation of an environment of safety for both patient and the health care/psychosocial clinician." (page 125-126)
14	Transparency, especially explanation of interventions, is crucial to help adult survivors with cancer to reality test their distortions and misinterpretations of the health professionals' intentions and motivations. [C]	"The clinician's explanation of interventions renders the counselling process transparent. Transparency is crucial to helping survivors of CSA with cancer to reality test their distortions/misperceptions of the health care/psychosocial clinicians' intentions and motivations." (page 126)
16	Health professionals must be particularly cautious in pacing older survivor's disclosure because, compared with younger survivors, they may be more hesitant to confront the terror of the trauma. [C]	"The therapist must be particularly cautious in pacing the client's disclosure of the abuse. Compared with younger clients, the older sexual abuse survivor may be more vacillating in confronting the terror of the incident and denying it." (page 168)
16	True empowerment of older female survivors may lie in respecting their conscious choice not to revisit the abuse. [C]	"True empowerment for these older women may lie in the therapists' respecting their conscious choice not to revisit the abuse." (page 171)
16	Therapists must approach older adult survivor's lifetime of defences and protective strategies with caution so as not to leave them defenceless or overwhelmed by their emerging awareness of the childhood trauma. [C]	"... a lifetime of defenses and protective strategies must be approached with caution so that the client is not left defenceless or over whelmed as she becomes increasingly aware of the traumatic event." (page 167)
20	Health professionals need to educate older female survivors about how abuse contributes to decreased coping capacities which in turn leads to feelings of low self-esteem. [C]	"The education process also helped the women understand how abuse contributes to decreased coping capacities, which in turn lead to experiences of low self-esteem." (page 109)
21	The ability of health professionals to communicate knowledge about the consequences of childhood sexual abuse, so that the older survivor can relate to this knowledge, can strengthen the therapeutic bond. [U]	"Women such as herself often avoid nakedness at all costs Mrs M. could relate to these experiences and stated for the first time in her life that she did not feel alone." (page 76)
21	Developing trust can be extremely difficult for older female survivors of childhood sexual abuse, even after years of therapy. [U]	"I worked with Mrs S. for three years, and developing trust was enormously difficult for her." (page 77)

23	The clinical team and the older adult survivor need to explain to each other the underlying meaning of their actions, because no change is sustainable unless it is meaningful to the person. [C]	"No change in humans, however achieved, is sustainable, unless it is meaningful to the person. The underlying meaning of certain actions – both by her and by the clinical team – was explained by and to her." (page 309)
24	It is of paramount importance that health professionals establish conditions of safety and security where older adult survivors can feel that they have some control. [C]	"...This cannot be said for survivors. For them, the establishment of conditions for safety and security, and for feeling in control, are of paramount importance." (page 167)
26	Older adult survivors should be given as much control as possible and attempts made to include them as a member of the treatment team. [C]	"Attempts should be made to include the patient as a member of the treatment team, giving as much control as possible to the patient." (page 16)

Refers to the Paper or Text Number from **Master Table 1. The Master Table of Texts**, in Appendix I
[U] = Unequivocal – beyond reasonable doubt; [C] = Credible – plausible in light of the information

Findings

Categories

Older female survivors may be hesitant to discuss any part of their life with the therapist because of uncertainty as to whom they can trust.

Therapists need the professional training to provide accurate information in an environment where the client feels they have permission to reveal their fears, desires and sexual concerns.

Exploration and healing is facilitated when the ongoing therapeutic relationship provides a safe place for the survivor to be vulnerable.

The therapeutic relationship is built on a rapport of caring, honesty and support.

Treatment should be based on an empathetic, real relationship with the therapist so that the older adult survivors do not feel judged and rejected.

The therapist may have to put in place measures such as regular phone contact if the older female survivor has expressed suicidal ideation.

Psychosocial interventions should address adult survivors' need to feel safe during cancer treatment, to contain intense feelings and distressing thoughts and to acquire more adaptive ways of self-comforting.

Acute symptoms of depression, including suicidal behaviour or self harm, require psychiatric intervention that takes precedence over cancer treatment, until the patient can be stabilised with medication.

The ability to exercise choice; a broader concept than just consent, is the key element in helping survivors with cancer to feel safe, to be in control, to explore options and to pace the introduction of new treatments.

Because childhood sexual abuse is such a profound boundary violation, it is important to maintain professional boundaries to create a safe environment for both survivor and health professional.

Transparency, especially explanation of interventions, is crucial to help adult survivors with cancer to reality test their distortions and misinterpretations of the health professionals' intentions and motivations.

Health professionals must be particularly cautious in pacing older survivor's disclosure because, compared with younger survivors, they may be more hesitant to confront the terror of the trauma.

True empowerment of older female survivors may lie in respecting their conscious choice not to revisit the abuse.

Therapists must approach older adult survivor's lifetime of defences and protective strategies with caution so as not to leave them defenceless or overwhelmed by their emerging awareness of the childhood trauma.

Health professionals need to educate older female survivors about how abuse contributes to decreased coping capacities which in turn leads to feelings of low self-esteem.

The ability of health professionals to communicate knowledge about the consequences of childhood sexual abuse, so that the older survivor can relate to this knowledge, can strengthen the therapeutic bond.

Developing trust can be extremely difficult for older female survivors of childhood sexual abuse, even after years of therapy.

The clinical team and the older adult survivor need to explain to each other the underlying meaning of their actions, because no change is sustainable unless it is meaningful to the person.

It is of paramount importance that health professionals establish conditions of safety and security where older adult survivors can feel that they have some control.

Older adult survivors should be given as much control as possible and attempts made to include them as a member of the treatment team.

2.1.1 Safety for the Older Adult Survivors

NOTARI-View 2.1.1 - Synthesis 2: Category 1.1 - Safety for the Older Adult Survivors

(Health Professionals' Experiences with Older Adult Survivors: A Systematic Review of Text and Opinion)

Adapted from the NOTARI-View diagrams output from the NOTARI Module of JBI-CReMS

2.1.2 Safety for Health Professionals

While it is important to provide a safe place for older adult survivors to be vulnerable and to heal, this is not possible unless health professionals also feel safe; have the expertise, the knowledge, the support and the self-awareness to identify older adult survivors in their care and then the courage to act on that knowledge appropriately, therapeutically and ethically.

2.1.2.1 Self-Awareness

Health professionals dealing with older adult survivors can experience distress because of their own unresolved issues or countertransferences; for instance if they have unresolved issues about their own older relatives.⁶¹ Davenport reports the case of an academic (called C) who was deeply distressed by the behaviour of an older female survivor, described by Davenport as a *“toxic older adult”*. Davenport reports that the distress had *“spilled into C’s home life, and there were many hours of cathartic listening by her spouse”*.⁶¹ Davenport argues that this situation arose because the academic had not dealt with issues related to her mother, and cautions that if it is not feasible to work through such countertransference issues, then the professional should refer the person and take care of themselves.⁶¹ Colarusso, a Clinical Professor of Psychiatry, and training and supervising Psychoanalyst, admits that despite his experience, he found himself *“reacting to the systematic, relentless cruelty of this man with a sense of amazement, revulsion, and fear”*.⁴⁷

2.1.2.2 Maintenance of Professional Boundaries

Gallo-Silver and Weiner caution that because childhood sexual abuse is such a profound boundary violation, the *“maintenance of professional boundaries contributes to the creation of an environment of safety for both patient and the health care/psychosocial clinician”*.⁴⁹

2.1.2.3 Education and Mutual Peer Support

McLean and Hales stress the importance of education and mutual support as well as formal and informal meetings between health professionals involved in the care of survivors with cancer, in maintaining a therapeutic relationship, when mistrust and worsening symptoms may threaten to demoralize the treating team.⁶⁷ Gallo-Silver and Weiner endorse the importance of case conferencing and supervision to provide a safe place where health professionals can *“examine and discuss their feelings of sadness and anger”*.⁴⁹

2.1.2.4 Professional Supervision

The text by Sutton illustrates the importance of professional supervision to help staff at all levels, deal with their *“feelings of inadequacy, disbelief and numbness”* and to stay focused on the needs of the older adult survivor.⁵² Sutton, a clinical psychologist specialising in aged care, also received support from peer supervision. This support provided safe conditions in which the specialist could also learn and develop from the experience.⁵² However, ultimately health professionals have to attend to their own healing because otherwise they will not be effective.^{47, 49, 52, 67}

2.1.2.5 Supporting and Validating Staff in Residential Aged Care

In the residential care setting, ongoing management of residents with disturbed even violent behaviour can demoralize staff and lead to excessive burnout and staff sickness.^{52, 66} Sutton argues that staff may not have a language to express their distress and that they may need to be listened to *“over and over before they can attend properly”* because of the stress of working so closely with traumatised people *“amid the difficulties of residential care generally”*.⁵² Sutton suggests that staff need their distress validated, that supervisors need to reflect back to them what they seem to be saying, while also emphasising the worth of the resident.⁵² Sutton also argues that while containment of strong emotions may be necessary for residents, the health professionals caring for them also need their own containment strategies.⁵²

Table 2.1.2 Safety for the Health Professionals*Findings that make up this Category and Illustrations from the Texts*

#	Finding	Illustration from Text
10	Countertransference, especially unresolved issues about their parents, may have a severe impact on the personal life of professionals dealing with very difficult older adults and result in hours of cathartic listening for their spouses. [U]	"... it was obvious that C was deeply distressed. The troubles had spilled into C's home life, and there were many hours of cathartic listening by her spouse. ...Although an exemplary professional in her field, C had never faced, or been able to cope with, her own mother's toxicity. T's presence had brought it all back. ...She became a co-Victim." (page 92-93)
10	It is important for health professionals to accept and work through counter-transference issues and, if this is not possible, then to refer appropriately and take care of themselves. [C]	"Accept and work through any hidden tendencies that might interfere with objective help and foster countertransference. If this is not feasible then refer and take care of yourself." (page 174)
14	Case conferencing and supervision need to provide health professionals with a safe environment to examine and discuss their feelings of sadness and anger. [C]	"Case conferencing and supervision need to provide health care/psychosocial clinicians with a safe environment to examine and discuss their feelings of sadness and anger." (page 126)
17	In palliative care, the treating team may be frustrated and demoralised by the mistrust of the older female survivor and her escalating symptoms towards the end of life. [U]	"In turn, her mistrust and escalating symptoms had the potential to frustrate and demoralize her treating team." (page 231)
17	Regular formal and informal meetings, education, and mutual support between the psychosocial and palliative care providers may help to maintain a healthy therapeutic relationship between the team and the older female survivor and family. [U]	"Through regular formal and informal meetings, education, and mutual support, the psychosocial and palliative care providers were able to maintain a therapeutic relationship with Heather and Steven." (page 231)
23	Repetitive self harm behaviour is a costly problem to manage, especially when associated with high rates of violence towards health professionals that can lead to excessive staff burnout and sickness. [C]	"RSH [Repetitive Self Harm] is a costly problem to manage, especially when associated with high rates of violence towards caregivers. It prevents patients from making use of available therapies and making progress and leads to excessive staff burnout and sickness." (page 310)
24	Staff in residential aged care may become distressed and feel that they have no control when confronted with a resident who has difficult behaviours. [U]	"Feelings were running high generally; staff felt out of control too." (page 157)
24	Staff in residential aged care have a great need to be listened to, sometimes over and over again, so that they can attend properly to the needs of the resident with behavioural problems, amid the general difficulties of residential care. [C]	"Staff often have a great need to be listened to. They often need to 'offload' a great deal, over and over and over before they can attend properly, because of the stress of working so closely with people as traumatised as Joan amid the difficulties of residential care generally." (page 167)

24	Staff in residential aged care may find it hard to express what is going on because they do not have a language or the constructions for what they are trying to say or do, and a suitably qualified professional may need to reflect back to them what they seem to be saying and what seems to be going on, to validate their feelings. [C]	"As staff talk, I often begin to realise that part of the problem is that they are finding it hard to put into words what is going on; they do not seem to have a language or the constructions for what they are trying to say or do. They have no 'signposts' themselves. Very quickly I find myself reflecting back to them what they seem to want to say ('yes Joan is worth it, because she is a human being') and what seems to be going on ('yes, this is a crisis – ...') and we need to work with that, helping them 'stay in the moment'." (page 167)
24	When distress levels are high among staff in residential aged care, containment, which carries connotations of safety, reassurance, boundary and strength, is essential. [C]	"When feelings are running high there is a need for 'containment'.... which 'carries connotations of safety, reassurance, boundary and strength' ...This was true for staff too." (page 157-158)
24	Peer support and supervision, at all levels, is important because it provides safe conditions for health professionals to learn and develop from their own experience and that of others. [C]	"My own support came from peer supervision with experienced psychotherapeutic and cognitive-behavioural practitioners. The importance of this cannot be overstated, because this provides the safe conditions in which the specialist her or himself can learn and develop from her or his own experience and that of others." (page 162)
24	Health professionals must think of their own healing when dealing with older people with severe disturbance. [U]	"I encouraged Ann [matron] to think of her own healing." (page 165)
	Professional supervision can help health professionals to deal with their own feelings of inadequacy, disbelief and numbness. [U]	"Supervision apparently helped Ann [matron] with her own feelings of inadequacy, disbelief and numbness." (page 166)
# Refers to the Paper or Text Number from Master Table 1. The Master Table of Texts , in Appendix I		
[U] = Unequivocal – beyond reasonable doubt; [C] = Credible – plausible in light of the information		

Findings

Categories

Countertransference, especially unresolved issues about their parents, may have a severe impact on the personal life of professionals dealing with very difficult older adults and result in hours of cathartic listening for their spouses.

It is important for health professionals to accept and work through countertransference issues and, if this is not possible, then to refer appropriately and take care of themselves.

Case conferencing and supervision need to provide health professionals with a safe environment to examine and discuss their feelings of sadness and anger.

In palliative care, the treating team may be frustrated and demoralised by the mistrust of the older female survivor and her escalating symptoms towards the end of life.

Regular formal and informal meetings, education, and mutual support between the psychosocial and palliative care providers may help to maintain a healthy therapeutic relationship between the team and the older female survivor and family.

Repetitive self-harm behaviour is a costly problem to manage, especially when associated with high rates of violence towards health professionals that can lead to excessive staff burnout and sickness.

Staff in residential aged care may become distressed and feel that they have no control when confronted with a resident who has difficult behaviours.

Staff in residential aged care have a great need to be listened to, sometimes over and over again, so that they can attend properly to the needs of the resident with behavioural problems, amid the general difficulties of residential care.

Staff in residential aged care may find it hard to express what is going on because they do not have a language or the constructions for what they are trying to say or do, and a suitably qualified professional may need to reflect back to them what they seem to be saying and what seems to be going on, to validate their feelings.

When distress levels are high among staff in residential aged care, containment, which carries connotations of safety, reassurance, boundary and strength, is essential.

Peer support and supervision, at all levels, is important because it provides safe conditions for health professionals to learn and develop from their own experience and that of others.

Health professionals must think of their own healing when dealing with older people with severe disturbance.

Professional supervision can help health professionals to deal with their own feelings of inadequacy, disbelief and numbness.

2.1.2 Safety for the Health Professionals

NOTARI-View 2.1.2 - Synthesis 2: Category 1.2 - Safety for the Health Professionals
(Health Professionals' Experiences with Older Adult Survivors: A Systematic Review of Text and Opinion)
Adapted from the NOTARI-View diagrams output from the NOTARI Module of JBI-CReMS

2.2 HEALTH PROFESSIONALS' EXPERTISE & KNOWLEDGE, AND VALUES & ATTITUDES

Health professionals in all fields and levels of practice, who may encounter older adult survivors, need to have knowledge about the consequences of childhood sexual abuse. They also need the knowledge and skills (dependent on their scope of practice) as well as the self-awareness and values and attitudes that ensure that they do not consciously or unconsciously misguide the direction of therapy.

2.2.1 Health Professionals' Expertise and Knowledge

Allers and colleagues contend that health professionals need to be educated about the dynamics and consequences of childhood sexual abuse so that they do not design inappropriate or inadequate treatment plans.⁴⁶ They further add that this education should challenge the myths that suggest that all limits in cognitive and emotional functioning are the result of 'normal aging'.⁴⁶ At a more practical level, they suggest that further professional training should include interviewing techniques and instruction in the evaluation and diagnosis of older adult survivors.⁴⁶

Colarusso argues that to manage the care of the older female survivors that he assessed, health professionals would need; experience, an understanding of the consequences of abuse, recognition of the fragility of the survivor and pacing that proceeded slowly and sensitively so as not to undermine vital defence mechanisms prematurely.⁴⁷

The age and experience of the therapist may be significant factors which assist older adult survivors to become fully engaged in the therapeutic process. Bergström-Walan suggests that *"Many elderly people feel most at ease with a therapist or counsellor of approximately their own age"*.⁵⁶

Health professionals also need to be aware of past and current social conditions so that they can educate older woman and facilitate their understanding of life course abuse in light of changing social attitudes.⁵¹

In health care settings where older adult survivors may be encountered, and abuse memories may re-emerge, for instance oncology and palliative care, health professionals' awareness and knowledge about childhood sexual abuse issues can assist them to use

appropriate interventions; such as containment, to minimise the re-traumatising effects of treatments and maximise the treatment experience for older adult survivors with cancer.⁴⁹

Osgood and Manetta state that health professionals need to be aware of the many factors associated with suicide; including childhood sexual abuse, so that they can identify underlying factors when an older adult expresses suicidal ideation.⁵¹

Bergström-Walan asserts that there are now a growing number of health professionals who are specialised in aged care, so that it should be possible *“to ensure that a sufficient proportion of these are also skilled in psycho-sexual therapy”* to care for older adult survivors with sexual problems.⁵⁶

Finally, Resnick-Cortes asserts that health professionals must continue to learn, grow and develop regardless of their years of experience.⁵⁵

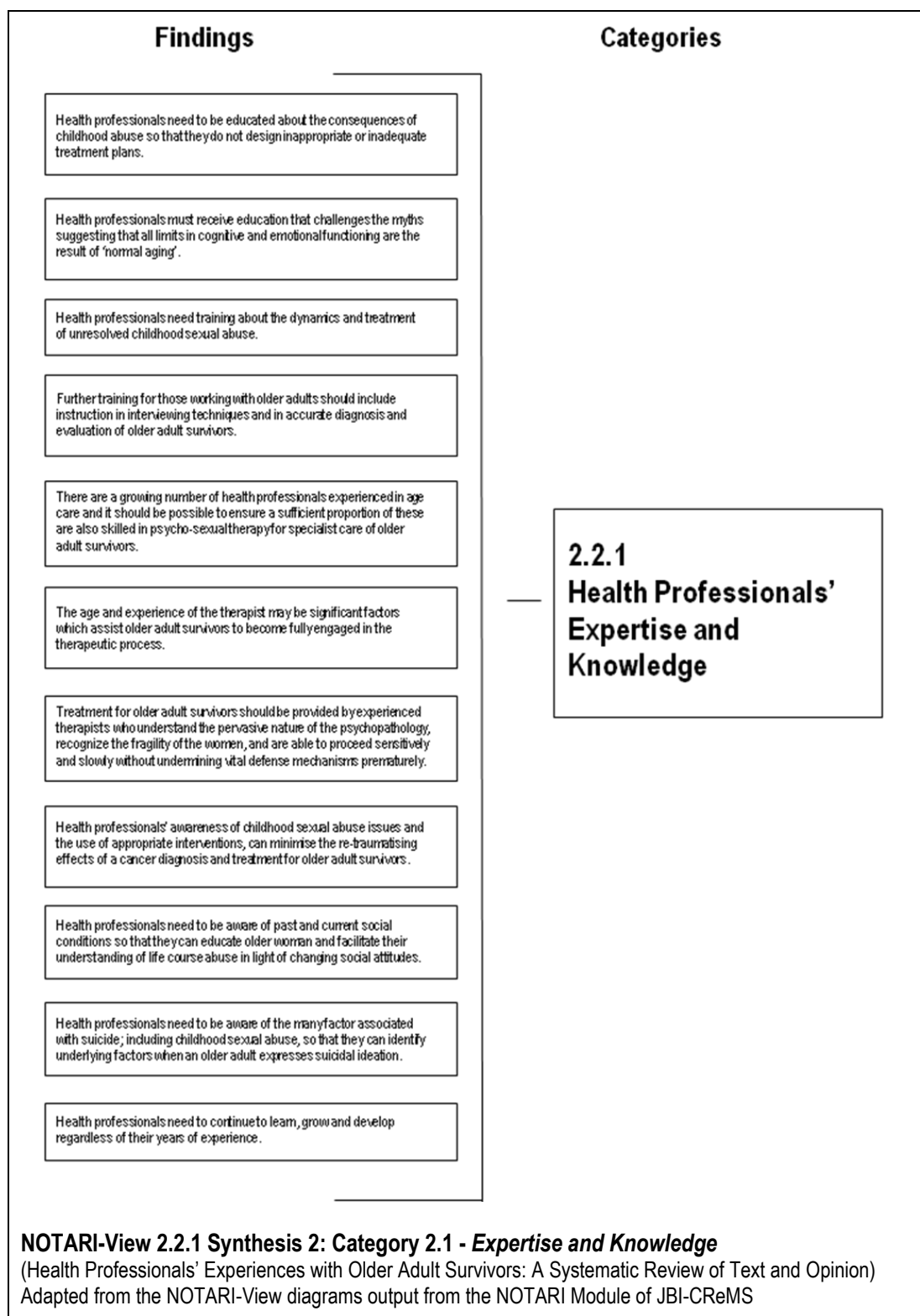
Table 2.2.1 Health Professionals’ Expertise and Knowledge

Findings that make up this Category and Illustrations from the Texts

#	Finding	Illustration from Text
1	Health professionals need to be educated about the consequences of childhood abuse so that they do not design inappropriate or inadequate treatment plans. [C]	"Hesitancy by the mental health community in becoming educated regarding childhood abuse-related phenomena will necessarily lead counselors to design inappropriate or inadequate treatment plans." (page 16)
1	Health professionals must receive education that challenges the myths suggesting that all limits in cognitive and emotional functioning are the result of ‘normal aging’. [C]	"Additionally, this education must challenge the myths suggesting that all limits in cognitive and emotional functioning are necessarily a result of ‘normal’ aging." (page 16)
1	Health professionals need training about the dynamics and treatment of unresolved childhood sexual abuse. [C]	"These challenges include training for professionals regarding the dynamics and treatment of unresolved childhood sexual abuse ..." (page 16)
1	Further training for those working with older adults should include instruction in interviewing techniques and in accurate diagnosis and evaluation of older adult survivors. [C]	"Further professional training for those working with older adults should include instruction in interviewing techniques and in accurately evaluating and diagnosing older adult survivors." (page 16)
5	There are a growing number of health professionals experienced in age care and it should be possible to ensure a sufficient proportion of these are also skilled in psycho-sexual therapy for specialist care of older adult survivors. [C]	"Fortunately there is now a growing number of experienced psychologists and other professionals who specialise in providing services to elderly people, and it should be possible to ensure that a sufficient proportion of these are also skilled psycho-sexual therapists." (page 37-38)

5	The age and experience of the therapist may be significant factors which assist older adult survivors to become fully engaged in the therapeutic process. [C]	"Many elderly people feel most at ease with a therapist or counsellor of approximately their own age ... the age and experience of the therapist are significant factors which assist older people who are seeking help with psycho-sexual problems to become fully engaged in the therapeutic process." (page 37)
8	Treatment for older adult survivors should be provided by experienced therapists who understand the pervasive nature of the psychopathology, recognize the fragility of the women, and are able to proceed sensitively and slowly without undermining vital defense mechanisms prematurely. [C]	"Treatment should be provided by experienced therapists who understand the pervasive nature of the psychopathology, recognize the fragility of the women, and are able to proceed sensitively and slowly without undermining vital defense mechanisms prematurely." (page 347)
14	Health professionals' awareness of childhood sexual abuse issues and the use of appropriate interventions, can minimise the re-traumatizing effects of a cancer diagnosis and treatment for older adult survivors. [C]	"Health care/psychosocial clinicians' awareness and use of appropriate interventions can minimize the effects of re-traumatization [of a cancer diagnosis and treatment] and enhance the CSA survivors' treatment experience." (page 108)
20	Health professionals need to be aware of past and current social conditions so that they can educate older woman and facilitate their understanding of life course abuse in light of changing social attitudes. [C]	"The social worker knew past and current social conditions and public laws, and used this knowledge to educate the women by helping them understand abuse in childhood and abuse in adulthood in light of changing social attitudes that have existed throughout time." (page 109)
20	Health professionals need to be aware of the many factor associated with suicide; including childhood sexual abuse, so that they can identify underlying factors when an older adult expresses suicidal ideation. [U]	"Geriatric social workers that are cognizant of the many factors associated with suicide can use their knowledge to identify underlying factors for suicidal statements. Childhood abuse, spouse abuse, and substance abuse are three individual factors that have been identified as risk factors for suicide." (page 110)
21	Health professionals need to continue to learn, grow and develop regardless of their years of experience. [U]	"I am reminded by these women and their stories that living is perhaps our greatest teacher and that I too continue to learn, grow, and develop regardless of my many years of experience." (page 79)

Refers to the Paper or Text Number from **Master Table 1. The Master Table of Texts**, in Appendix I
[U] = Unequivocal – beyond reasonable doubt; [C] = Credible – plausible in light of the information



2.2.2 Health Professionals' Self-Awareness, Values and Attitudes

2.2.2.1 Hesitancy to Explore and Unsure How to Deal with 'IT'

McInnes-Dittrich reasons that health professionals "*hesitancy to explore issues concerning sexuality and early sexual experiences with older clients may contribute to misdiagnosis*".⁵⁰ Osgood and Manetta argue that while increased public discussion may lead women to talk more about their abuse experiences, "*many clinicians are unsure how to deal with this information and help these women*".⁵¹ Walter says that some of her colleagues in gerontology admitted feeling uncomfortable assessing for a history of incest.⁶³ The reasons behind this discomfort and hesitancy are complex but based on conscious and unconscious issues around aging and sexuality.

2.2.2.2 Misguiding Therapy

Several of the texts discuss the effects that ageism, sexism, sexuality in old age, and body image issues, can play in misguiding therapy.^{56, 57, 59, 62} Altschuler and Katz (1996) argue that when health professionals have "*an array of rich material from which to choose, countertransference may guide the direction of therapy*" so that the history of abuse is ignored and more accessible areas are pursued.⁵⁷ These authors in a later, 2010 paper, further this argument to propose that time constraints, inexperience as well as countertransference may lead to a focus on the presenting problem rather than integrating this with underlying concerns.⁶²

Croze discusses the therapeutic opportunity that can be lost if there is a failure to identify transference, because the therapist is inexperienced and/or the older female survivor is old enough to be their grandmother. An inexperienced male therapist may fail to identify sexual transference that could be used therapeutically to improve the quality of life of the older woman, who probably has little contact with younger males.⁵⁹

Moyer in her paper about sibling relationships among older adults discusses how "*ageism or lack of information about multigenerational relationships*"⁶⁸ may result in health professionals ignoring the support that may be available through sibling relationships. They may see relationship difficulties without understanding or pursuing the reasons behind

these, such as sexual abuse by the father that was never disclosed to each other, and which tainted their relationships for decades.⁶⁸

2.2.2.3 *Gaining New Insights*

Health professionals not only need to be self-aware,⁶⁹ but also sensitive enough to be able to expand that awareness with new insights.⁵⁵ Resnick-Cortes says that even *“with all of my training, with all of my experience, with the expertise I knew I had, I neglected to really comprehend the impact of violation”*.⁵⁵ The violation revealed here, was touch during personal care over which the older female survivor had no control. Sutton also encouraged care staff to understand the feelings behind the behaviour expressed by an older female survivor and consider how they would like to be treated if they felt that way.⁵²

2.2.2.4 *Facing Difficult Questions*

As well as the values and attitudes held by health professionals that will influence their management of older adult survivors, there can be very difficult ethical considerations. The paper by Hill about the older male survivor, who claimed to have abused children in his care in the past, highlights the ethical dilemmas faced by health professionals when the rights of the client are at variance with the safety of the community.⁶⁵ The tension for Hill and his colleagues was between what they did and what they perhaps should have done; *“We decided not to contact the scout troop ... arguably we should have tried”*.⁶⁵

Miesen and Jones touch on *“the difficult questions”*⁶⁰ that may have to be faced if health professionals suspect that a son is physically and sexually abusing his mother, in this case a woman with dementia. They state that *“too often, because of the inadequacy of our knowledge and understanding, the choice we make tends to be somewhat ‘hit and miss’”*.⁶⁰

In the text by Sutton there was the ethical consideration of the survivor’s privacy versus the needs of the daughter who also seemed to have abuse issues. This was resolved by providing a separate counsellor for the daughter.⁵²

Similarly, if an older female survivor improves during therapy and gains insight into her re-victimisation, but remains in an abusive relationship, then her safety may be compromised and her health professionals may have to put a safety plan in place.⁴⁸

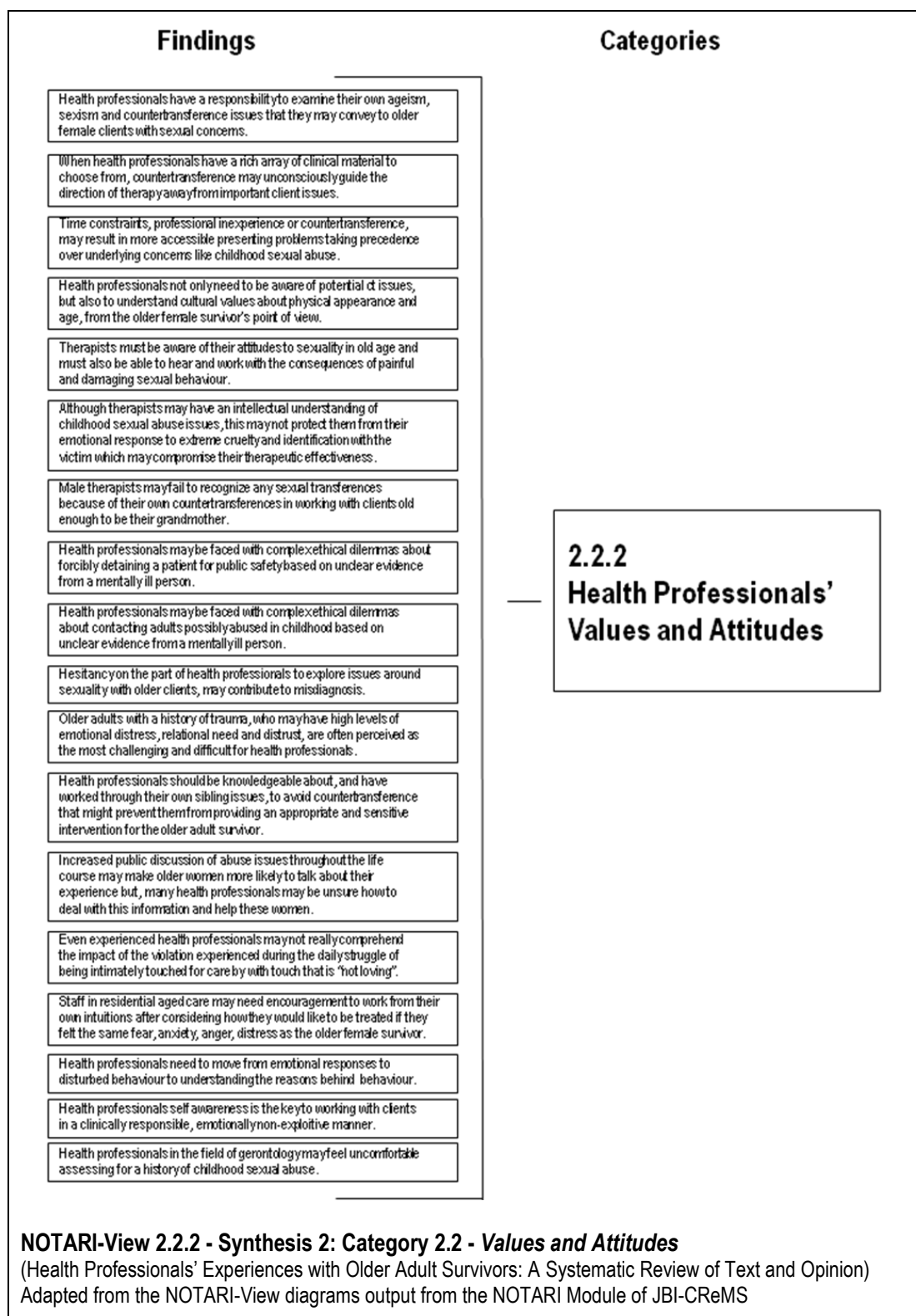
Table 2.2.2 Health Professionals' Values and Attitudes*Findings that make up this Category and Illustrations from the Texts*

#	Finding	Illustration from Text
2	Health professionals have a responsibility to examine their own ageism, sexism and countertransference issues that they may convey to older female clients with sexual concerns. [U]	"A practitioner has a responsibility to examine personal ageism, sexism and countertransference limitations unconsciously conveyed to an older female client with sexual concerns." (page 54)
2	When health professionals have a rich array of clinical material to choose from, countertransference may unconsciously guide the direction of therapy away from important client issues. [C]	"When the practitioner has an array of rich material from which to choose, countertransference may guide the direction of therapy. ... although Mrs L had previously revealed this information to a psychiatrist who she saw for several years, 'she seemed more interested in my ex-husband's manic-depressive behaviour and never asked me any questions about incest.'" (page 57)
3	Time constraints, professional inexperience and/or countertransference, may result in more accessible presenting problems like carer stress, taking precedence over and not being integrated with, any underlying concerns like childhood sexual abuse. [U]	"The profession of social work is geared toward developing the ability to integrate clients' presenting problems and underlying concerns. Unfortunately, the latter often takes a back seat to the former, sometimes due to time constraints, sometimes due to the worker's inexperience, and sometimes due to countertransference." (page 201) "The worker attributed the overeating and weight gain to caregiver stress, not the incest." (page 206)
3	Health professionals not only need to be aware of potential countertransference issues, but also to understand cultural values about physical appearance and age, from the older female survivor's point of view. [C]	"Equally important is the need for workers to be aware of potential countertransference reactions that may inhibit older women from fully discussing their concerns, and to learn about the client's cultural values about physical appearance and age from her point of view." (page 210)
5	Therapists must be aware of their attitudes to sexuality in old age and must also be able to hear and work with the consequences of painful and damaging sexual behaviour. [C]	"So far as older people struggling with the consequences of earlier trauma are concerned, this last point is particularly relevant. The therapist will need to examine his/her attitude to sexuality in old age and must also be able to hear and work with the consequences of painful and damaging sexual behaviour." (page 38)
8	Although therapists may have an intellectual understanding of childhood sexual abuse issues, this may not protect them from their emotional response to extreme cruelty and identification with the victim which may compromise their therapeutic effectiveness. [U]	"The nature of psychopathic sadism ... provided an intellectual basis for understanding but did not protect me from my emotional response.... the analyst's reaction to the extreme cruelty and identification with the victim, may compromise the therapist's ability to help the patient..." (page 348)
9	Male therapists may form a strong therapeutic relationship with older female survivors but fail to recognize any sexual transferences because of their own countertransferences in working with clients old enough to be their grandmother. [U]	"Jeff, a doctoral student, developed a strong therapeutic alliance with Edna ...but he ignored the sexual nature of her interactions with him. Because she was old enough to be his grandmother, it did not occur to him that she might be experiencing sexual feelings toward him." (page 70)

15	Health professionals may be faced with complex ethical dilemmas about forcibly detaining a patient for public safety based on unclear evidence from a mentally ill person. [U]	"What should we tell the police, regarding the possible risk to local children? At this stage we had no clear evidence on which to assess whether he was a child abuser or not ... Arguably, he should have been detained to protect the public and himself, from the time of admission." (page 137)
15	Health professionals may be faced with complex ethical dilemmas about contacting adults possibly abused in childhood based on unclear evidence from a mentally ill person. [U]	"We decided not to contact the scout troop in question to make further enquiries. ... not only would this have been impractical but we felt that this course of action was unlikely to improve these men's lives and could be disturbing for them... Arguably, we should have tried." (page 138)
16	Hesitancy on the part of health professionals to explore issues around sexuality and early sexual experiences with older clients, may contribute to misdiagnosis. [C]	"A therapist's hesitancy to explore issues concerning sexuality and early sexual experiences with older clients may contribute to misdiagnosis." (page 167)
17	Older adults with a history of trauma, who may have high levels of emotional distress, relational need and distrust, are often perceived as the most challenging and difficult for health professionals. [C]	"Due to high levels of emotional distress, relational need and distrust, patients with histories of trauma are often perceived as the most challenging and difficult for health care providers." (page 229)
19	Health professionals should be knowledgeable about, and have worked through their own sibling issues, to avoid countertransference that might prevent them from providing an appropriate and sensitive intervention for the older adult survivor. [C]	"Practitioners should be knowledgeable about and have worked on their feelings about their own sibling relationships to avoid having their unresolved countertransference issues prevent them from doing an accurate and sensitive intervention in this area for their older adult clients." (page 58)
20	Increased public discussion of abuse issues throughout the life course may make older women more likely to talk about their experience but, many health professionals may be unsure how to deal with this information and help these women. [C]	"With the increased public discussion of physical and sexual abuse in childhood and battering in adult relationships, women are now talking about their experiences, yet many clinicians are unsure how to deal with this information and help these women." (page 100)
21	Even experienced health professionals may not really comprehend the impact of the violation that older adult survivors can experience during the daily struggle of being intimately touched for personal care by others whose touch is "not loving". [U]	"The daily struggle of being intimately touched by others whose touch was not loving engulfed me.... With all of my training, with all of my experience, with the expertise I knew I had, I neglected to really comprehend the impact of violation." (page 76)
24	Staff in residential aged care may need encouragement to work from their own intuitions after considering how they would like to be treated if they felt the same fear, anxiety, anger, distress as the older female survivor. [C]	"In terms of how best to be with Joan when she was like this therefore, I asked staff to consider, for each state in turn, if they were feeling like that, how would they like people to be with them? I encouraged them to work from their own intuitions (just as Joan was having to follow hers)." (page 159)

24	Health professionals need to move from their emotional responses to disturbed behaviour to understanding the person and the reasons behind their behaviour. [U]	"Ann suggested that as a specialist I had been able to 'put it all into words', taking her, 'from the behaviours to understanding the person'. Joan was not a 'mental patient' she said: she had an image of Joan as a mad woman running down the corridor changing the clocks, when all that it meant was that time had stood still for her." (page 166)
25	Health professionals self awareness is the key to working with clients in a clinically responsible, emotionally non-exploitive manner. [C]	"The key to working with our patients and clients in a clinically responsible, emotionally nonexploitive manner is self-awareness." (page 529)
26	Health professionals in the field of gerontology may feel uncomfortable assessing for a history of childhood sexual abuse. [U]	"... and some [colleagues in the field of gerontology] admitted to feeling uncomfortable doing so [assessing for a history of incest]." (page 15)

Refers to the Paper or Text Number from **Master Table 1. The Master Table of Texts**, in Appendix I
[U] = Unequivocal – beyond reasonable doubt; [C] = Credible – plausible in light of the information



2.3 IDENTIFICATION AND DISCLOSURE ISSUES

All health professionals involved in the care of older adults are in a position to recognise the signals and identify older clients who may be affected by unresolved issues related to childhood sexual abuse. Older adults go to health professionals for all sorts of reasons not explicitly related to their abuse. They present in complex and often disguised ways, sometimes expressing their distress in behaviours and fragmentary memories decades after the events.

Disclosure of the abuse needs to be individually timed and paced with consideration given to the physical health and resilience of the older adult survivor. Older adult survivors may be reluctant to disclose their abuse for many reasons, including previous ill-fated attempts. They may also be unable to disclose because the abuse is not accessible to memory or because of cognitive impairment.

2.3.1 *Identifying Older Adult Survivors – Recognising the Signals*

2.3.1.1 *The Cost of Not Identifying Survivors*

Allers and colleagues emphasise the damage that can be done in “*circumventing effective mental health assistance*”⁴⁶ if older adult survivors are not diagnosed, treated and the response to that treatment evaluated properly, if at all. They assert that in such cases mental health professionals have failed to assist their clients to heal.⁴⁶

2.3.1.2 *The Signals are Embedded in Complex and Diverse Presentations*

Older adults rarely present for problems explicitly related to childhood sexual abuse, even when that presentation is for a psychotherapeutic intervention.^{48, 50} Relational Table 1.4 The Presenting Problems, in Appendix I, outlines the presenting problems for the 38 older adult survivors described in the texts. Depressive symptoms were the largest grouping, with twelve presentations, plus another eleven for affect disorders including suicidal ideation, grief, anxiety, social isolation and stress. Behavioural difficulties were involved in four presentations including repetitive self-harm, two with ‘challenging’ behaviours in residential aged care and one difficult older college student. Three cases presented during physical treatment; two for cancer treatment and two with psychotic behaviour. Many of those with depressive symptoms also elicited a history of depression, a lifetime of unhappiness, or

feelings of hopelessness and low self-esteem. Several of the presentations were subsequently diagnosed with Posttraumatic Stress Disorder, usually of a chronic nature.⁴⁷

2.3.1.3 Chronic Depression Warrants Inquiry

Allers and colleagues assert that it is important for mental health professionals to examine an older person's history of depression because those *"reporting long-term depression are particularly likely to have had abusive childhoods"*.⁴⁶ Gagnon and Hersen also endorse the need to assess chronically depressed older adults for abuse histories.⁴⁸ Wadeson expands the likely presenting disorders to include not only depression but *"substance abuse, attachment disorders, or some combination of these conditions"*.⁶⁹ McInnes-Dittrich further suggests that *"symptoms of unresolved sexual abuse in older adults frequently resemble the depression, anxiety, or dissociation observed in patients with mild to moderate dementia"*.⁵⁰ Gagnon and Hersen advise that not all depression, anxiety and guilt in old age are linked to unresolved childhood sexual abuse, but that it should be *"considered to be a possibility that warrants thorough therapeutic inquiry"*.⁴⁸

2.3.1.4 Somatic Manifestations May Not Be Organic or the Result of Ageing

Health professionals may also attribute presenting symptoms in older adults, to the effects of ageing.^{46, 48, 50} McInnes-Dittrich argues that this may occur because in *"older adults, depression and anxiety are frequently exhibited in somatic, rather than emotional complaints"*.⁵⁰ Rosik discusses the exceptional case of an older female survivor who had a Dissociative Identity Disorder that was misdiagnosed for years and that resulted in numerous surgeries for somatic manifestations.⁵⁸ Allers and colleagues also suggest that in the older person, distressing feelings may be expressed through *"behaviors and emotional reactions that seemed to the uniformed professional as symptoms of organic pathology"*.⁴⁶

2.3.1.5 Behavioural Manifestations – 'IT' Makes Sense

Sutton also highlights the expression of distress through 'challenging' behaviours in the older person in residential care who *"is unable to speak of what she or he endured or to put into words what is wrong"*.⁵² While the older female survivor was seen as 'lazy' and 'difficult', Sutton says that her behaviour made sense in terms of the long-term effects of

past abuse.⁵² Sutton adds that it is difficult to know how many people traumatised in their youth are now living in residential care with untreated mental health problems.⁵²

Gagnon and Hersen suggest that mental health professionals working with older adults *“remain sensitive to age-related stressors their clients may encounter and how such stressors may reawaken negative emotions”*.⁴⁸

Table 2.3.1 Identifying Older Adult Survivors

Findings that make up this Category and Illustrations from the Texts

#	Finding	Illustration from Text
1	It is important for health professionals to examine the history of the older person's depression because those reporting chronic depression are particularly likely to have had abusive childhoods. [C]	"Counselors working with older adults should routinely examine the history of the older client's depression. Clients reporting long-term depression are particularly likely to have had abusive childhoods..." (page 15)
1	Inaccurate diagnosis of unresolved issues stemming from childhood sexual abuse as mental illness or dementia and improper evaluation of psychopharmacological treatment may result in ineffective treatment for years. [C]	"This case study illustrates the role that an inaccurate diagnosis of sexual abuse as dementia or mental illness can play in circumventing effective mental health assistance. ... By treating the client with medication and improperly evaluating her response to psychopharmacological treatment, mental health professionals failed to assist the client in addressing her unresolved feelings ...stemming from childhood abuse." (page 15)
1	Unresolved feelings of anger and helplessness suffered by older adult survivors, may be expressed through behaviours and emotional reactions that to the uninformed professional may seem to be symptoms of organic pathology. [C]	These feelings [anger and helplessness] were demonstrated through behaviors and emotional reactions that seemed to the uninformed professional as symptoms of organic pathology." (page 15)
10	Older adults may be reluctant to seek help for psychological distress so time, patience and recognising nonverbal clues are the essence of identification. [C]	"Older adults of the Depression generation especially are not prone to share their emotional pain ... Time and patience, and watching for nonverbal clues, are of the essence. (page 15)
13	Older adult survivors are likely to present for psychotherapeutic intervention with complaints that do not explicitly suggest a history of childhood sexual abuse. [C]	"Complicating matters, adult survivors are likely to present for psychotherapeutic intervention with complaints that do not explicitly implicate a history of CSA..." (page 190)
13	Health professionals may attribute presenting complaints such as depression or anxiety, to the direct effects of ageing, and not to an exacerbation of a long-standing problem. [C]	"Mental health professionals may inadvertently misattribute presenting complaints of depression or anxiety to the direct effects of aging instead of viewing these factors as an exacerbation of a long-standing problem." (page 190)
13	Health professionals working with chronically depressed older adults should routinely investigate the clients' childhood histories for signs of abuse. [C]	"Mental health professionals working with chronically depressed older adults should routinely investigate clients' childhood histories for signs of CSA and other abuse experiences." (page 193)

13	Health professionals who work with older adults should remain sensitive to the age related stressors their clients may encounter, and understand how such stressors may reawaken negative emotions from the past. [C]	"The task for mental health professionals who work with older adults is to remain sensitive to the age-related stressors their clients may encounter and how such stressors may reawaken negative emotions." (page 196)
13	Health professionals should incorporate a thorough investigation of abuse histories in their interviewing and assessment techniques for all older adults. [C]	"Interviewing and assessment techniques should incorporate a thorough investigation of a potential abuse history." (page 196)
13	Not all depression, anxiety and guilt in old age are connected to unresolved childhood sexual abuse; rather, past abuse should be considered as a possibility that warrants thorough therapeutic inquiry. [C]	"...this report is not intended to imply that all depression, anxiety, and guilt in old age are connected to unresolved CSA. Rather, unresolved CSA should be considered to be a possibility that warrants thorough therapeutic inquiry." (page 196)
14	Early identification of survivors of childhood sexual abuse with cancer would be helpful in anticipating and planning for their increased need for psychosocial support. [C]	"Early identification of survivors of CSA with cancer would be helpful in anticipating and planning for their increased need for psychosocial and/or psychiatric support services." (page 126)
14	Some survivors of childhood sexual abuse with cancer have no memory of the abuse and this may only become apparent in a crisis situation in the midst of treatment. [U]	"The potential inaccessibility of memories of CSA suggests the likelihood that some survivors of CSA with cancer would be unable to self-identify and inform health care/psychosocial professionals. Therefore it is possible that a cancer patient's history of CSA may become apparent to the health care/psychosocial team in the midst of treatment, similar to the crisis situations described..." (page 127)
16	Unresolved childhood sexual abuse is rarely the explicit presenting problem for clients approaching the mental health system, regardless of their age. [U]	"Unresolved sexual abuse is rarely the presenting problem for clients approaching the mental health system, regardless of age." (page 167)
16	The symptoms of unresolved childhood sexual abuse in older adult survivors may resemble the depression, anxiety and dissociation seen in those with mild to moderate dementia. [C]	"Symptoms of unresolved sexual abuse in older adults frequently resemble the depression, anxiety, or dissociation observed in patients with mild to moderate dementia." (page 166)
16	In older adults, depression and anxiety are frequently exhibited as somatic complaints, which may be accepted by health professionals as an inevitable part of the physical changes of ageing. [C]	"In older adults, depression and anxiety are frequently exhibited in somatic, rather than emotional, complaints and may be accepted as an inevitable part of the physical changes accompanying aging." (page 167)
20	Older female survivors may have hidden their history of alcohol misuse because they believe there is a stigma associated with it, and so do not seek professional help. [C]	"Because older women often consider alcohol use to be a moral deficiency and believe there is a stigma associated with alcohol misuse ... they hide their alcohol abuse and do not seek help from professionals." (page 102)
20	Older female survivors may have replaced their alcohol misuse with the more "acceptable" prescription drug misuse. [C]	"...elderly women are most often addicted to prescription drugs rather than to "street drugs."" (page 102)

21	The inability of some frail older female survivors to accept help with personal hygiene may stem from sexual abuse in childhood, and may result in angry outbursts and uncooperative behaviour. [U]	"After several sessions, Mrs M. Revealed to me that her inability to accept help with personal hygiene, especially as it related to the washing of her "private parts" stemmed from having been sexually abused by her father in childhood. ... Touch, any touch, is frequently misinterpreted and re-enacts earlier violations." (page 76)
22	Health professionals can misinterpret the signs and symptoms of a dissociative disorder that may manifest in physical expressions of emotional distress [somatoform dissociation], resulting in unnecessary medical and surgical interventions over many years. [U]	"The patient's medical records suggest that primary and secondary symptoms now commonly associated with DID [Dissociative Identity Disorder] were misinterpreted by a variety of health care providers for over three decades." (page 65) Her records and reports indicated at least eleven surgeries for a variety of conditions since her early 30s." (page 63)
24	It is difficult to estimate how many people, traumatised in their younger days, are now 'living in silence' in residential care with unattended mental health problems. [U]	"It is difficult to estimate how many people who have been traumatised in their younger days now live in residential care, who may be 'living in silence' still ... with unattended mental health problems ..." (page 156)
24	If the older person is unable to speak because of physical or cognitive impairment, then it is even more difficult to understand the core of their distress, which may be related to childhood sexual abuse. [U]	"It is even more difficult if the person is unable to speak of what she or he endured or to put into words what is wrong." (page 156)
24	The 'difficult' behaviours of older female survivors may make sense in terms of the long-term effects of childhood sexual abuse, so that the original experiences of humiliation and degradation can bring fear and soiling and shock. [C]	"She was not 'just a difficult person', or 'lazy' as her daughter proposed. Indeed her behaviour would make sense in terms of the long-term effects of past abuses ... how original experiences of humiliation or degradation can bring fear and soiling and shock." (page 159)
25	Survivors of childhood sexual abuse may enter therapy with diagnoses of depression, substance abuse, attachment disorders or some combination of these not explicitly related to childhood sexual abuse. [U]	"Many enter therapy with diagnoses of depression, substance abuse, attachment disorders, or some combination of these conditions." (page 99)
26	Health professionals in the field of gerontology may have never considered assessing for a history of childhood sexual abuse. [U]	"Most [colleagues in the field of gerontology] had never considered assessing for a history of incest ..." (page 15)
26	Although social work professionals may be attuned to a history of childhood sexual abuse in their elderly clients, many survivors in active psychiatric treatment are still not identified. [C]	"In general, it appeared that social work colleagues [gerontology] were more vigilant for an incest history. One social work colleague in particular believed the number of elderly incest survivors in active psychiatric treatment or in need of it is much higher than we know." (page 15)
26	Assessment of the elderly for possible childhood sexual abuse is important if health professionals are to understand their presenting symptoms and interpersonal relationships. [C]	"Assessment of geriatric patients to determine their possible status as incest survivors is important for understanding presenting symptoms and interpersonal dynamics." (page 16)

Refers to the Paper or Text Number from **Master Table 1. The Master Table of Texts**, in Appendix I
[U] = Unequivocal – beyond reasonable doubt; [C] = Credible – plausible in light of the information

Findings

It is important for health professionals to examine the history of the older person's depression because those reporting chronic depression are particularly likely to have had abusive childhoods.

Inaccurate diagnosis of unresolved issues stemming from childhood sexual abuse and improper evaluation of psychopharmacological treatment may result in ineffective treatment for years.

Unresolved feelings of anger and helplessness may be expressed through behaviours and emotional reactions that to the unformed professional may seem to be symptoms of organic pathology.

Older adults may be reluctant to seek help for psychological distress so time, patience and recognising nonverbal cues are the essence of identification.

Older adult survivors are likely to present for psychotherapeutic intervention with complaints that do not explicitly suggest a history of childhood sexual abuse.

Health professionals may attribute presenting complaints such as depression or anxiety, to the direct effects of ageing, and not to an exacerbation of a long-standing problem.

Health professionals working with chronically depressed older adults should routinely investigate childhood histories for signs of abuse.

Health professionals who work with older adults should remain sensitive to the age related stressors their clients may encounter, and understand how such stressors may reawaken negative emotions from the past.

Health professionals should incorporate a thorough investigation of abuse histories in interviewing and assessment techniques for all older adults.

Not all depression, anxiety and guilt in old age are connected to unresolved childhood sexual abuse; rather, past abuse should be considered as a possibility that warrants thorough therapeutic inquiry.

Early identification of survivors of childhood sexual abuse with cancer would be helpful in anticipating and planning for their increased need for psychosocial support.

Some survivors of childhood sexual abuse with cancer have no memory of the abuse and this may only become apparent in a crisis situation in the midst of treatment.

Unresolved childhood sexual abuse is rarely the explicit presenting problem for clients approaching the mental health system, regardless of their age.

Categories

2.3.1 Identifying Older Adult Survivors

Part 1 of 2

Findings

Categories

The symptoms of unresolved childhood sexual abuse in older adult survivors may resemble the depression, anxiety and dissociation seen in those with mild to moderate dementia.

In older adults, depression and anxiety are frequently exhibited as somatic complaints, which may be accepted by health professionals as an inevitable part of the physical changes of ageing.

Older female survivors may have hidden their history of alcohol misuse because they believe there is a stigma associated with it, and so do not seek professional help.

Older female survivors may have replaced their alcohol misuse with the more "acceptable" prescription drug misuse.

The inability of some frail older female survivors to accept help with personal hygiene may stem from sexual abuse in childhood, and may result in angry outbursts and uncooperative behaviour.

Health professionals can misinterpret the symptoms of a dissociative disorder that may manifest in physical expressions of emotional distress, resulting in unnecessary medical and surgical interventions.

It is difficult to estimate how many people, traumatised in their younger days, are now 'living in silence' in residential care with unattended mental health problems.

If the older person is unable to speak because of physical or cognitive impairment, then it is even more difficult to understand the core of their distress, which may be related to childhood sexual abuse.

'Difficult' behaviours of older female survivors may make sense in terms of long-term effects of childhood sexual abuse, the original experiences of humiliation and degradation can bring fear and soiling and shock.

Survivors of childhood sexual abuse may enter therapy with diagnoses of depression, substance abuse, attachment disorders or some combination of these not explicitly related to childhood sexual abuse.

Health professionals in the field of gerontology may have never considered assessing for a history of childhood sexual abuse.

Although social work professionals may be attuned to a history of childhood sexual abuse in their elderly clients, many survivors in active psychiatric treatment are still not identified.

Assessment of the elderly for possible childhood sexual abuse is important if health professionals are to understand their presenting symptoms and interpersonal relationships.

2.3.1 Identifying Older Adult Survivors

Part 2 of 2

NOTARI-View 2.3.1 - Synthesis 2: Category 3.1 – Identifying Older Adult Survivors

(Health Professionals' Experiences with Older Adult Survivors: A Systematic Review of Text and Opinion)

Adapted from the NOTARI-View diagrams output from the NOTARI Module of JBI-CReMS

2.3.2 Disclosure Issues for Older Adult Survivors

The disclosure histories identified from the texts for the 38 older adult survivors, are listed in Relational Table 1.3. in Appendix I. Often as children, older adult survivors were blamed, ostracised, threatened with death or hell. Signs of physical and sexual abuse were even ignored by health professionals. At least four of the older adult survivors had never told anyone about their abuse. Two survivors had previously told psychiatrists, who as reported by the survivors, were more interested in other aspects of their lives and did not question them further about the abuse. Even during current therapy, it may have taken many months to years for survivors to disclose their abuse. For several of the older adult survivors with cancer, memories of the abuse only emerged in a crisis situation, during treatment.

2.3.2.1 Only Apparent in a Crisis

In many health fields, such as oncology, early identification of an abuse history would be helpful in anticipatory planning for the increased need for psychological support for adult survivors.⁴⁹ However, Gallo-Silver and Weiner caution that because memories of childhood sexual abuse can be inaccessible, then some survivors with cancer may be unable to self-identify and that their history may only become apparent in the middle of treatment, possibly in a crisis situation requiring acute psychiatric intervention.⁴⁹

2.3.2.2 Ask

The process of disclosure may be facilitated in some case by “*simply inquiring*”.⁵⁹ McInnes-Dittrich also endorses the benefits of asking about an abuse history because “*some women actually experienced symptom relief after being asked*”.⁵⁰

2.3.2.3 Listen and Observe for Non-Verbal Cues

Sutton highlights the importance of just listening because some older adult survivors may rarely, if ever, have talked about their abuse and feel that no one has, is or will listen.⁵² Also by just listening, older adult survivors can maintain some control of their disclosure.⁵² Davenport suggests that the Depression Generation, of now older adults, are not prone to sharing their emotional pain and that health professionals need to take time and have the patience to observe for non-verbal cues to distress.⁶¹

2.3.2.3 Approach Defences with Caution

McInnes-Dittrich also cautions that *“a lifetime of defenses and protective strategies must be approached with caution so that the client is not left defenceless or overwhelmed”* as they become more aware of their past traumatic experiences.⁵⁰ In one case, the older female survivor took a year to build up enough trust to reveal her abuse and so was *“encouraged to talk about it at her own pace”*.⁵⁰ The therapist may also have to slow the pace of the older adult survivors' revelations so that they are not left so vulnerable that they repress their thoughts in future sessions.⁵⁰

2.3.2.4 Assess for a History of Abuse

Gagnon and Hersen suggest that *“interviewing and assessment techniques should incorporate a thorough investigation of a potential abuse history”*.⁴⁸ Walters endorses this view and states that if presenting symptoms and interpersonal dynamics are to be understood, older adults should be assessed for incest.⁶³ However, she also notes that most of her colleagues in gerontology, had never considered assessing for such an abuse history, although her social work colleagues were more vigilant in this regard.⁶³

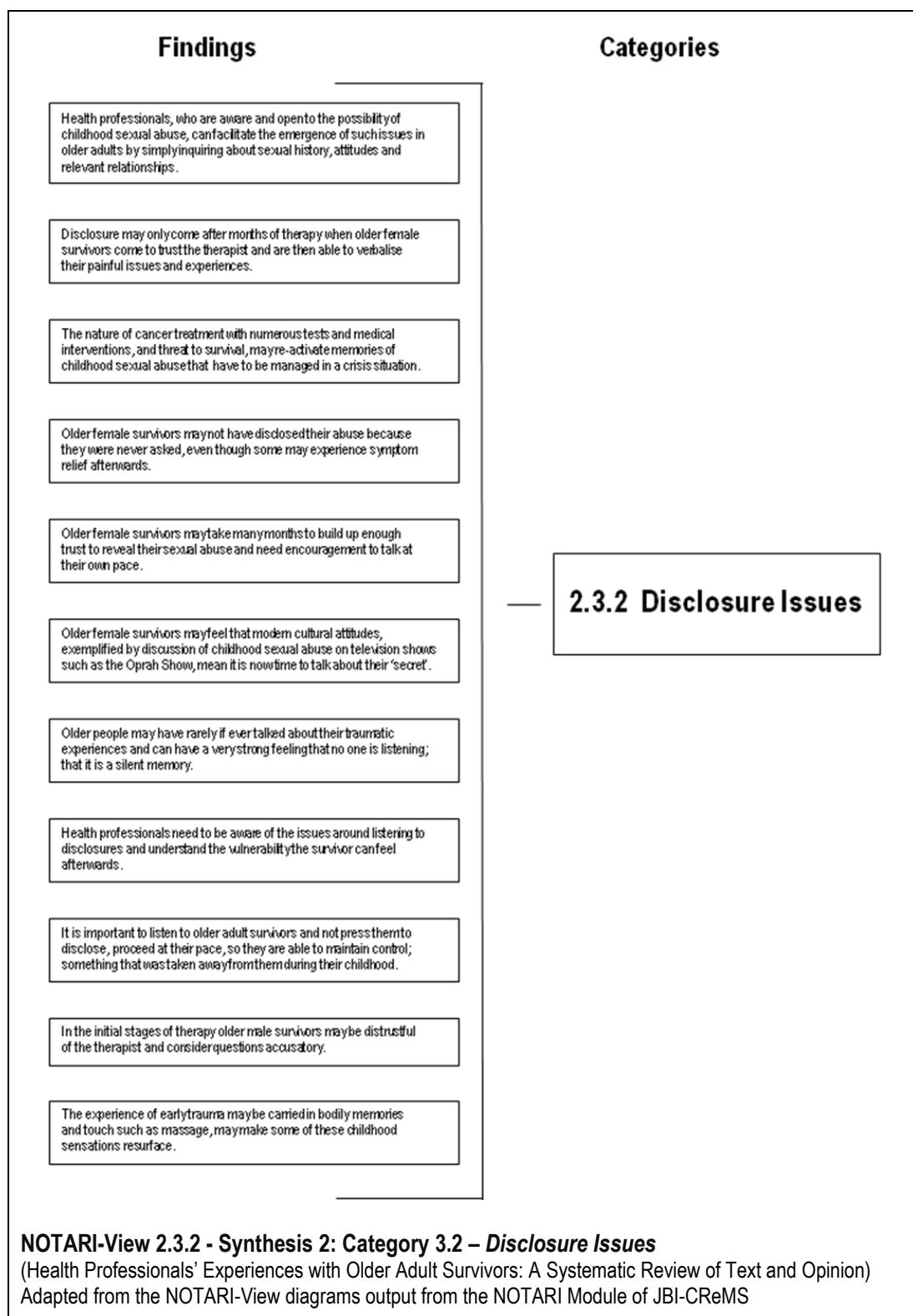
Table 2.3.2 Disclosure Issues for Older Adult Survivors

Findings that make up this Category and Illustrations from the Texts

#	Finding	Illustration from Text
9	Health professionals, who are aware and open to the possibility of childhood sexual abuse, can facilitate the emergence of such issues in older adults by simply inquiring about sexual history, attitudes and relevant relationships. [C]	"A clinician who is aware and open to the possibility can facilitate the emergence of these issues during the course of therapy by simply inquiring about sexual history, attitudes, and relevant relationships." (page 67)
11	Disclosure may only come after months of therapy when older female survivors come to trust the therapist and are then able to verbalise their painful issues and experiences. [U]	"After three months, a big break came in her ability to trust and verbalize very painful issues and experiences." (page 48)
14	The nature of cancer treatment with numerous tests and medical interventions, plus the threat to survival, may re-activate memories of childhood sexual abuse that may need to be managed in a crisis situation. [U]	"The nature of cancer treatment comprised of numerous medical interventions, tests and procedures, and threat to survival can re-activate memories of CSA." (page 126)

16	Older female survivors may not have disclosed their abuse because they were never asked, even though some may experience symptom relief afterwards. [U]	"... many older women did not disclose a history of sexual abuse because they were never asked. Some women actually experienced symptom relief after being asked about possible sexual abuse." (page 167)
20	Older female survivors may take many months to build up enough trust to reveal their sexual abuse and need encouragement to talk at their own pace. [U]	"Since she had taken a year to build up enough trust to reveal the sexual abuse, Veronica was encouraged to talk about it at her own pace." (page 107)
20	Older female survivors may feel that modern cultural attitudes, exemplified by open discussion of childhood sexual abuse on television shows such as the Oprah Show, mean it is now time to talk about their 'secret'. [U]	"She stated that it was time to talk about the sexual abuse, "because it is the 1990's and people don't keep it a secret any more. I have heard people talking about it on Oprah...."" (page 105)
24	Older people may have rarely if ever talked about their traumatic experiences and can have a very strong feeling that no one is listening; that it is a silent memory. [C]	When I meet people who have been through traumatic experiences which have rarely, if ever, been talked about, or that they have not been allowed to talk about, the feeling that no one is listening can be very strong (and they may not be listening still). It is a kind of silent memory." (page 155)
24	Health professionals need to be aware of the issues around listening to disclosures and understand the vulnerability the survivor can feel afterwards. [C]	"She also began to disclose to Ann abuses by her brother when they were young, and issues of her difficulties or fear of men arose. Ann and I explored the issues around listening to disclosures and understanding the vulnerability the person can feel afterwards and, to maintain the control with Joan, Ann did not disclose the precise confidences to me." (page 163)
24	It is important to listen to the older adult survivor and not press them to disclose, to proceed at their pace, so that they are able to maintain control of their own issues; something that was taken away from them during their childhood abuse. [C]	"Ann and I agreed not to press her ... but to listen, because it is extremely important to enable the client to maintain control of her or his own issues, as in abuse and maltreatment this is precisely what has been taken away..... If Joan wished to disclose, then Ann would of course listen, but otherwise she attended to her care of Joan in other ways, such as encouraging her to develop her self-care or to develop interests ..." (page 161)
25	In the initial stages of therapy older male survivors may be distrustful of the therapist and consider questions accusatory. [U]	"Initially, Mike was distrustful of me and found my occasional questions accusatory. Eventually, however, he became less defensive ..." (page 100)
25	The experience of early trauma may be carried in bodily memories and touch such as massage, may make some of these childhood sensations resurface. [C]	"The experience of early trauma is so often carried in bodily memories that it seemed that for Mike the massage experience touched off some of these childhood sensations." (page 101)

Refers to the Paper or Text Number from **Master Table 1. The Master Table of Texts**, in Appendix I
[U] = Unequivocal – beyond reasonable doubt; [C] = Credible – plausible in light of the information



2.4 PRINCIPLES OF THERAPEUTIC MANAGEMENT

Matching Goals to Needs, Maintaining Focus, Evaluating and Ending

The survivors identified in the review texts are a culturally diverse group of older adults with ages ranging from sixty to ninety years (see Relational Table 1.1 The Older Adult Survivors, in Appendix I). The older adult survivors include a healthy sixty year old Chicago businessman,⁶⁹ a sixty year old Canadian woman with terminal cancer,⁶⁷ a relatively unsophisticated group of rural Appalachian women⁵⁰ and an elderly Dutch lady with dementia.⁶⁰ The first authors; not necessarily the treating professionals, are largely psychologists (9), social workers (8) and psychiatrists (5) with two nurses, one counsellor and a neurologist (see Master Table 1 in Appendix I). The older adult survivors have been treated in their own homes, day centres, psychogeriatric inpatient wards, forensic psychiatric hospitals, oncology wards, residential aged care facilities, private rooms, a community college and acute hospital settings (see Relational Table 1.5 The Treatments and Therapies, in Appendix I).

It is not surprising then, that **no single model of care has emerged** from the texts. However, the authors have provided some principles for the care of these older adult survivors. Many of these principles have already been touched on when discussing the ability of experienced self-aware health professionals, to identify older adult survivors with problems possibly related to their childhood sexual abuse, and to act on that recognition within an environment of safety.

2.4.1 *Individually Based, Safe, Holistic Care*

While there is no one model of care, any model needs to be holistic and built on a therapeutic foundation of safety. Capasso introduces one holistic framework based on “Newman’s theory of health as expanding consciousness” that shifts the focus from a “curative to a healing practice of nursing” so that health professionals come to know the whole person and not just the ‘part’ that requires their current attention.⁶⁴ Miesen and Jones; discussing the care of an elderly survivor with dementia, state that while goals and interventions may change as dementia progresses, the “core goal is always the same: to

*realise the 'ownness', 'individuality' or 'identity' of the person; to enable him or her to trust others and to feel trusted; and to facilitate psychological or emotional safety".*⁶⁰

2.4.2 Understanding, Empathy, Caring and 'Tough Love'

Sutton emphasises that health professionals need to move on from identifying 'difficult' behaviour to understanding the distress behind that behaviour and the cause of that distress.⁵² Resnick-Cortes illustrates how this understanding in the hands of empathic and caring health professionals can help older adult survivors to differentiate between their current distressing experiences, and the abuse they suffered in childhood, and so enable them to accept warmth and care from others, to improve their quality of life.⁵⁵

However, Davenport cautions that when dealing with the group of older adults with 'challenging behaviours' that she identifies in her book *'Working with Toxic Older Adults'* health professionals have to "... maintain the balance between caring involvement and professional detachment, be firm, and remember to apply tough love".⁶¹

2.4.3 Determine Goals, From Ongoing Help to Resolution

McInnes-Dittrich states that "*challenging lifelong defense mechanisms, accessing remote memory, confronting absent perpetrators of abuse, and preserving self-empowerment in older women are important tasks for both client and therapist*" and suggests that by helping older female survivors to process and resolve abuse issues they will be empowered to reclaim control over their lives.⁵⁰

While resolution may be the ideal, Miesen and Jones question whether it should be the only goal of intervention. They see the main purpose of the intervention to be more pragmatic; an ongoing helping process rather than some future resolution of a problem.⁶⁰

Sutton adds that it is not the health professional's responsibility to 'cure' the older adult survivor; which could be an unrealistic expectation for both professional and survivor, but to help them to improve their quality of life.⁵² Crose gives the example of how caring male health professionals can use transference, such as flirtatious behaviour from their older female clients, to enrich the lives of these older, frail women who may have few males in their lives.⁵⁹

2.4.4 Changing Goals, Becoming More Supportive or Palliative

The goals may be more dynamic than suggested above, changing over time and due to circumstances. When older adult survivors have progressive disorders that compromise physical and/or cognitive functioning such as terminal cancer, physical frailty or dementia, then the goal of psychological care may become more palliative.^{52, 60, 67} Miesen and Jones suggest that this involves providing as much emotional support and comfort as possible and allowing the survivor to experience as often as possible, moments of overt happiness.⁶⁰

According to Sutton, the conventional aim of psychotherapy; to lower defences, expose the pain and work through it, may be inappropriate for severely traumatised older adult survivors, especially if physically compromised.⁵² The focus should be more supportive, establishing safety and helping the older adult survivor to feel in control.⁵²

McLean and Hales twist this focus slightly to look at the death of an older female survivor with chronic affect and relationship problems with cancer. In this case the authors suggest that more realistic (and less paternalistic) expectations of a “good enough” death may free the survivor from a struggle with professionals trying to impose idealised death expectations.⁶⁷

2.4.5 Changing Focus, Moving On To More Difficult Issues

As older adult survivors proceed through therapy and resolve some of their abuse related issues, the focus may also change, for instance onto more difficult issues. Gagnon and Hersen discuss an older male survivor who, while he could come to terms with many of his own abuse issues, was quite distraught because of his sexual abuse of his younger sister, who was now dead and so never able to forgive him.⁴⁸

2.4.6 Focus on Strengths

Health professionals working with older adult survivors should focus on their past coping strategies, strengths and accomplishments rather than their losses and dependencies, and affirm the courage needed to endure the despair they may be experiencing.^{52, 55, 63}

Sutton suggests that the artificial dichotomy between ‘successful ageing’ and ‘mental health problems’ results in health professionals rarely according courage to older people who

show severe disturbances.⁵² Sutton amplifies the theme of courage in the face of despair, when she talks of survivors being “*strong at the broken places*” asserting that understanding this concept is the foundation of work with survivors.⁵²

As part of a strength-based approach, health professionals need to provide older adult survivors with the information they need to challenge their negative self-schemas and improve their coping skills. This may require health professionals to educate older adult survivors to recognise and use more mature reasoning to connect their current negative self-perceptions with their childhood abuse, for which they were not responsible.^{46, 48, 56}

Osgood and Manetta discuss using the vehicle that propelled the older female survivor to disclose her abuse, as a means to normalise her feelings.⁵¹ In the example given, the therapist pointed out that many of the women appearing on the Oprah Show on television, who had suffered childhood sexual abuse, felt they were not as good as other people, just as the survivor did.⁵¹

Health professionals can also teach older female survivors self-care that includes exercises to improve their self-esteem, practical attention to their physical and mental wellbeing and improving their ability to make more appropriate personal decisions.⁵¹

2.4.7 Address Negative Beliefs and Emotions

While antidepressants may provide some symptomatic relief, they do not address and correct negative beliefs and self-perceptions which must be dealt with to minimise the possibility of further victimisation such as elder abuse.^{43, 46, 48} According to Benbow the mainstay of treatment is the opportunity for the older adult survivor to “... *share experiences, and to reflect on their effects and their meaning*”.⁴³ Walter adds that the older adult survivor may have had “*limited opportunities to discuss their abuse experiences and so health professionals should encourage reminiscence and ventilation of their emotions*”.⁶³

The expression of anger at the perpetrator, and the parents who were seen to do nothing, may be viewed as a positive indicator that an older male survivor has relinquished some of the guilt and blame he feels, for the abuse he suffered as a child.^{48, 69}

2.4.8 Pacing and Containment

It is important for health professionals to monitor the pace of the intervention, and the effect this may be having on older adult survivors' feelings of being in control. Wadeson talks about an older male survivor who became overwhelmed by the pain that resurfaced during art therapy - *"I told him he could take a break from it. He drew a shade pulled down so he would not have to look at 'all the miseries of my life'"*.⁶⁹

In some instances the dynamics of pacing may be very complex. Sutton gives the example of an older female survivor who was assumed to be 'getting better' when she was seen to be doing more, causing her to feel pressured to 'get better', which again took away her control, and so she relapsed.⁵²

Another important aspect of pacing is containment of intense affect and distressing memories that may occur if there is an immediate stressor requiring *"crisis intervention or assistance with active problem-solving"*.⁶³ In the paper by Gallo-Silver and Weiner examples are provided of two older adult survivors who required containment techniques when distressing memories re-emerged during their cancer treatments in a crisis situation.⁴⁹ In one of the cases the survivor was in danger of harming herself and agreed to a brief psychiatric admission. In both these cases, the older adult survivors were able to make a choice to focus on their physical recovery before exploring their abuse issues.⁴⁹

2.4.9 Understand the Dynamics of Current Relationships

Understanding the dynamics of current relationships is important when managing the care of older adult survivors. Linked or interdependent lives, as discussed in the first synthesised finding, demonstrate the destructive and protective aspects, as well as the richness and poverty of close family relationships. During therapy, family issues may become apparent that need attention. The health professional may be faced with the need to maintain confidentiality for the survivor while supporting a family member such as a daughter who may also have abuse issues, by involving a separate health professional.⁵²

The older adult survivor and their spouse may need couple counselling for marital issues⁶⁷ or the spouse may need separate counselling for alcohol related issues.⁵⁶ If the relationship

is currently or potentially abusive the health professional may need to put in place a safety-plan.⁴⁸ Significant current turmoil in the family may need to be taken into account.⁴⁵

Moyer stresses that, *“for many older adults, siblings are the only surviving support system”*.⁶⁸ She asserts that health professionals should evaluate complicated sibling dynamics when they are assessing an older person’s support system before making premature judgements about what is going on.⁶⁸ The two sisters and a brother that Moyer describes, had handled their part of the *“...heavy secret by avoiding emotional closeness with each other”* for decades.⁶⁸

2.4.10 Ongoing Evaluation and Plans for Termination

Evaluation of the therapeutic intervention must be an ongoing process, during which adjustments can be made to the treatment plan as required, in conjunction with plans for termination.⁵¹ Sutton says that health professionals need to be aware of issues about termination from the beginning of care especially when loss; including the loss of one’s own life, is such an important part of working with older people.⁵²

2.4.11 Continue to Learn and Gain New Insights

Resnick-Cortes highlights the capacity for health professionals; even very experienced ones, to learn and gain insights from their work with older female survivors that can be incorporated into their future practice. She says that working with *“elderly, abused women reinforced for me that who we are transcends what we are. Armed with this insight I have learned to focus more on thoughts, feelings, past accomplishments, and contributions, rather than on loss of capacities, frail physicality, recent dependencies, and losses, when I work with the aged population”*.⁵⁵

Table 2.4 Principles of Therapeutic Management*Findings that make up this Category and Illustrations from the Texts*

#	Finding	Illustration from Text
1	Antidepressants may provide some immediate symptom relief but they do not address or correct the negative beliefs and self-perceptions developed as a result of childhood abuse. [C]	"Although antidepressants may have provided the client with some immediate relief from her symptoms, medication would not have addressed or corrected the negative beliefs and self-perceptions she developed as a result of childhood abuse." (page 15)
1	Health professionals need to assist older adult survivors to recognise that negative beliefs and self-perceptions can be the result of abusive childhoods, for which they are not responsible.[C]	"It is important for older adults to recognize that distorted perceptions can be the result of abusive childhoods for which they are not responsible." (page 15)
1	Health professionals should address low self-esteem and negative feelings resulting from childhood sexual abuse to minimise the possibility of continuing abuse, such as elder abuse. [C]	"In addition, the client's low self-esteem and negative feelings about himself or herself resulting from early childhood sexual trauma must be examined to minimize the possibility of continued abuse in future relationships." (page 16)
4	The mainstay of treatment for unresolved childhood sexual abuse is the opportunity to share experiences, and to reflect on their effects throughout life and their meaning. [C]	"The GP prescribed anti-depressant drugs, but the mainstay of treatment was the opportunity to share experiences, and to reflect on their effects and their meaning." (page 268)
5	Psychotherapy may help older female survivors to connect their current problems with their childhood sexual abuse, and so facilitate more mature and reflective reasoning.[U]	"At this stage she was able to connect her current problems with her childhood sexual abuse. Her fear gradually diminished and more mature and reflective reasoning began to take over." (page 34)
7	Based on a theoretical framework of Expanding Consciousness, nursing practice can shift the focus of care from the efficient completion of tasks to healing the whole person.[C]	"Newman's theory of Health as Expanding Consciousness provides the framework for a paradigm shift from a curative to a healing practice of nursing." (page 226) Emphasis would shift from efficient completion of tasks to centering and presencing with patients to really come to know the whole person." (page 229)
7	When health professionals understand the reasons for the older person's behaviour, then management becomes more straightforward. [C]	"When insight occurs, no matter how complex the situation, the solution is simple. " (page 228)
9	Male health professionals who can accept and use sexual transferences supportively and therapeutically can be very effective in treating and enriching the lives of older women who may have very few males in their lives. [C]	"Older women have few males in their lives, especially non-relatives. They value caring male health professionals and often respond to them with flirtatious or sexual overtones ... Men who can accept and use these relationships supportively and therapeutically can be very effective in treating and enriching the lives of older, frail, or disabled women." (page 70)
10	When dealing with "toxic" or very difficult older adults, health professionals must maintain a balance between caring involvement and professional detachment, be firm, and be able to apply tough love. [C]	"... maintain the balance between caring involvement and professional detachment, be firm, and remember to apply tough love." (page 174)

11	Termination of therapy may lead to feelings of anger and abandonment for the older female survivor. [U]	"When I told her I was terminating my sessions with her (and my position at the center) she became very angry and expressed the feeling that I was abandoning her." (page 49)
11	Older female survivors may resist any reference to psychosocial problems or therapy during interactions with a therapist and prefer to consider them as "talks". [U]	"She consistently resisted any reference to psychosocial problems, refusing to call our sessions "therapy", and considered them "talks". (page 48)
13	The failure of antidepressants to offer symptomatic relief should highlight the importance of addressing and correcting the negative beliefs of the older adult survivor. [C]	"The fact that no antidepressant medications offered symptomatic relief highlights the importance of addressing and correcting negative beliefs ..." (page 193)
13	Therapists may need to educate older male survivors about the behaviours commonly observed in sexually abused children, including hyper-sexuality with sexual acting-out and re-victimisation. [U]	"Saul was educated about the effects of CSA, including increased frequency of hypersexuality and sexual acting-out [sexual abuse of his sister] and increased risk for revictimization commonly observed in sexually abused children." (page 195)
13	Older male survivor's ability to express anger at those who hurt them may be viewed as a positive indicator that they have relinquished some of the blame. [C]	"Saul came to express considerable anger at his father and male perpetrators, which was viewed as a positive indicator in that he had relinquished some of the blame for CSA." (page 196)
13	While older male survivors may resolve many of the issues around their own sexual abuse, the focal point of therapy may become the more difficult issue of guilt over their sexual abuse of a sibling. [U]	"However, he continued to be quite distraught by the abuse he inflicted upon his sister, which became a focal point in therapy." (page 196)
14	Adult survivor's adherence to cancer treatment may be improved by containment of intense affect and distressing thoughts rather than exploration of them. [U]	"Containment of intense affect and distressing thoughts rather than exploration improved CSA survivors' adherence with cancer treatments." (page 108)
14	Older adult survivors with cancer can be helped to make a choice to focus on physical recovery, without either denying or ignoring their history of childhood sexual abuse. [U]	"Jose was able to make a conscious choice to focus his attention on his recovery without either denying or ignoring his history of CSA." (page 121)
15	If an older male survivor is also a child abuser, then to protect the public from possible risk, appropriate agencies may have to be involved in special "at risk" meetings. [U]	"We decided that our duty to protect the public from possible risk was sufficient that we had to involve other agenciesA special "at risk" meeting was called, to which various agencies were invited, including Mr X's general practitioner and the police." (page 138)
16	The aim of therapy with older female survivors is to empower them to reclaim control over their lives. [C]	"Helping an older woman to process and resolve childhood sexual abuse is intended to empower the survivor to reclaim control over her life." (page 171)
16	Challenging lifelong defence mechanisms, accessing remote memory, confronting absent perpetrators and preserving self-empowerment in older female survivors are important tasks for both client and therapist. [C]	"Challenging lifelong defense mechanisms, accessing remote memory, confronting absent perpetrators of abuse, and preserving self-empowerment in older women are important tasks for both client and therapist." (page 166)

16	In work with survivors of all ages it is important for health professionals to minimise the possibility of producing false memories of abuse by remaining as neutral as possible when exploring contextual clues. [C]	"In work with survivors of all ages, it is imperative that therapists remain as neutral as possible while exploring contextual clues in order to minimize the possibility of producing unauthentic memories." (page 168)
17	Health professionals may need to focus on a more realistic individualised "good enough" death for those older survivors with cancer who have chronic affect and relational instability, and for whom idealised expectations may lead to unwinnable struggles for control of distress. [C]	"For many health care providers, the idealized "good" death is one without distress and with death acceptance and preparation. For many individuals and families this may not be possible, particularly if there is a long history of chronic affect and relational instability. In fact, for many patients, imposition of idealized death expectations by health care providers may lead to struggles for control and autonomy and entrench patients in a pessimistic and hopeless outlook. In these cases, a focus on an individualized "good enough" or acceptable death may be more realistic and less paternalistic." (page 2231)
18	Resolution is not always the only goal of professional intervention but rather there may be the need for a range of changing goals; from resolution to palliation, to help older adult survivors to progress through their grieving process. [C]	"Resolution is possible – but we question whether resolution should always be the only goal of intervention or of providing care. Might we not instead speak in terms of helping people with a continuing progression through the grieving process?" (page 151)
18	While the goals of treatment and care might need to change as dementia progresses, the core goals remain the same; to realise the individuality of the person to enable them to trust and feel trusted and to feel safe. [C]	"The interventions for care-giving in dementia must fit the stage of the dementia process ...The core goal is always the same: to realise the 'ownness', 'individuality' or 'identity' of the person; to enable him or her to trust others and to feel trusted; and to facilitate psychological or emotional safety." (page 152)
18	If health professionals are aware of the history of attachments and losses of people with dementia, their behaviours and emotions such as sadness, fear, anxiety, anger, restlessness may be understood and responded to appropriately. [C]	"... we can trace how her behaviour may be understood and responded to in light of her history of attachments and loss and in the context of her progressive dementia Mrs De Bever exhibited ...sadness, fear, anxiety, anger and restlessness..." (page 150)
18	Palliative psychological treatment in dementia, aims to bring psychological comfort by providing moments of overt happiness, contentment, meaningful relationships, maximum orientation and alertness and participation in meaningful activities. [C]	"The goal was now palliative: to provide as much emotional comfort and support as possible....experience, as often as possible and either alone or in groups, of moments of overt happiness (indicated by smiling, laughing, singing or dancing)" (page 151)
19	Health professionals should evaluate complicated sibling dynamics, which may include childhood sexual abuse issues, when assessing an older person's care giving support system before judging the situation. [C]	"When assessing the caregiving support system for an ailing parent or older adult sibling, practitioners should evaluate the complicated sibling dynamics before coming to any premature conclusions about what is going on." (page 58)
20	The primary role of the health professional is to be comfortable with the silence surrounding disclosure of abuse and then to proceed slowly at the older survivor's pace. [C]	"The primary role of the social worker was to be comfortable with the silence that surrounded disclosure of abuse, and then allow Veronica to reveal small amounts of information at a time." (page 107)

20	Health professionals may have to slow the pace of older female survivors' revelations so that the woman is not left feeling too vulnerable, and in turn, repress their feelings in future sessions. [C]	"At times the social worker needed to prevent Veronica from revealing too much information because revealing too much information could have left her with feelings of vulnerability that in turn may have caused her to repress her thoughts in future sessions." (page 107)
20	Evaluation must be an ongoing process, during which adjustments can be made to the treatment plan as required, in conjunction with plans for termination. [C]	"Evaluation was an ongoing process during which adjustments were made to treatment plans as needed. Evaluation was also used in conjunction with termination." (page 109)
20	The vehicle that allowed the older female survivor to disclose their abuse; such as the Oprah Show on television, may be used by the therapist to normalise the survivor's feelings, pointing out the many women with similar feelings of inadequacy. [C]	"Using the vehicle that allowed her to open up – the Oprah show – the social worker tried to normalize her feelings by pointing out to her that many women who appear in the show and who have suffered childhood sexual abuse feel like they are not as good as other people." (page 109)
20	Health professionals can teach older female survivors self-care that includes exercises on building self-esteem and how to identify and manage physical and mental health problems and make sensible personal decisions. [C]	"The social worker also taught the women self-care. Self-care included exercises on building self-esteem and how to control and identify physical and mental health needs and how to make personal decisions." (page 109)
21	Through caring and empathy, health professionals can help older female survivors to differentiate between current distressing experiences in a residential care setting from earlier childhood sexual abuse, and come to accept the warmth and caring of others. [C]	"My job was to help her differentiate these current experiences from the past. I was able to demonstrate to her, through my caring, that she was lovable. In accepting my empathetic response to her, she opened herself up to the warmth and caring of others." (page 77)
21	Health professionals working with the aged population should focus on their strengths; their thoughts, feelings, accomplishments and contributions, rather than the loss of capacity, frail physicality, recent dependencies and losses. [C]	"Working with elderly, abused women reinforced for me that who we are transcends what we are. Armed with this insight I have learned to focus more on thoughts, feelings, past accomplishments, and contributions, rather than on loss of capacities, frail physicality, recent dependencies, and losses, when I work with the aged population." (page 78)
22	Older adult survivors may not be seen in therapy as often as desirable because of monetary constraints necessitating a more supportive approach to treatment. [U]	"Due to monetary constraints the patient could only be seen on a bi-weekly to monthly basis, necessitating a more supportive approach to treatment." (page 64)
23	Health professionals can respond sensitively, knowledgeably and proactively to difficult behaviour if their shared knowledge gives them the capacity to reasonably predict states and triggers of autonomic and emotional arousal. [C]	"It involved a shared knowledge of various 'causes' or 'triggers', the capacity to reasonably predict states of autonomic and emotional arousal and possible behavioural 'outputs', so as to respond sensitively, knowledgeably and proactively." (page 310)
24	Health professionals can create conditions where older female survivors feels safe to learn and develop, when they move on from diagnosing behaviours to understanding what the person is possibly going through. [C]	"We were going through this transition, moving from 'diagnosing' Joan's 'states' to understanding what she was possibly going through. Then we were able to create the conditions in which Joan would feel safe to learn and develop." (page 161)

<p>24 Health professionals need to affirm and reaffirm that older female survivors expressing 'difficult' behaviours, are not children but mature people with good resources, who are often scared. [C]</p>	<p>"Through Joan's difficult behaviours, especially when so regressed, it was tempting to see her as a child. It was important not to collude with this feeling but to stand back and look at the whole. We always tried to affirm and reaffirm Joan as a mature woman of great resources, albeit one who at times was scared." (page 163)</p>
<p>24 The artificial dichotomy between 'successful ageing' and 'mental health problems' is not helpful when dealing with older adult survivors who show severe disturbances, rather, health professionals should recognise the courage needed to endure the intense fear and despair they are obviously suffering. [C]</p>	<p>"Courage through fear and despair is rarely accorded to people who, when they are older, show severe disturbances. Rather there is an artificial dichotomy between those who are seen as in good mental health, with notions such as 'successful ageing', and those seen in terms of 'mental health problems'." (page 165)</p>
<p>24 It is important to proceed at the older female survivor's pace, even when they seem to be 'getting' better', because at this time there may be pressure to 'get better', and so control may be taken away and they may relapse. [C]</p>	<p>"Ann noticed that when Joan 'opened up', for example starting to go out more, eventually 'The Wall' would go up again and old anxieties would return. She was opening up old wounds, however, and the difficulty was that if Joan started to do more, this was taken as a sign of her 'getting better'. The pressure was then on her to 'get better': control was being taken away again. ... Always we reaffirmed the need to proceed at Joan's pace ..." (page 163)</p>
<p>24 Family issues may surface during care, and it is important to secure confidentiality for the older female survivor while providing support for their family. [U]</p>	<p>"At this point, the family issues surfaced more clearly. ...We felt it important to secure confidentiality for Joan, yet support Ruth [daughter]. A therapist from our team therefore offered support for Ruth .." (page 162)</p>
<p>24 Health professionals do not have to 'cure' older female survivors rather, the aim should be to improve their quality of life. [C]</p>	<p>"If Ann found she was getting anxious about Joan's recovery, she was to try and remember that she did not have to 'cure' her: this was about Joan's quality of life; it was palliative intervention." (page 163)</p>
<p>24 Issues of 'termination' are extremely important in psychological work and health professionals need to be aware of this from the beginning of care, especially when loss is such an important part of working with older people. [C]</p>	<p>"It was time to put limits on Ann's work, and a volunteer companion was arranged for social time for Joan outside of the home.and also time to look ahead to the end of my support of Ann. Issues of 'termination', of endings, are extremely important in psychological work and need to be prepared for. Indeed it is important to be aware of this from the beginning, where loss, including facing the loss of one's own life, is very much a part of working with older people." (page 164)</p>

24	The conventional aim of psychotherapy; to lower defences, expose the pain and work through it, may be inappropriate for severely traumatised older adult survivors, rather, the aim may be supportive, where safety is established and the survivor helped to maintain control. [C]	"... in its association of the 'working through' of issues, the aim of psychotherapy, ... is conventionally to help the person to lower her or his defences so that the pain is exposed and then it may be worked through. For people as traumatised as Joan, however, this is not advised. Rather the aim is for 'supportive psychotherapy'... For them [survivors], the establishment of conditions for safety and security, and for feeling in control, are of paramount importance." (page 167)
24	The foundation of work with older adult survivors must be based on an understanding of what it is to be 'strong at the broken places' and to promote their wisdom, ego-integrity and self-worth. [C]	"....what of the wisdom, ego-integrity and self-worth of those in fear and despair, particularly for people as disturbed as Joan? We need to secure an understanding of this in order to understand what it is to be 'strong at the broken places' to secure the foundations of work with survivors." (page 165)
25	During therapy, older male survivors may be able to vent their anger at the abusers and their parents, and apportion the blame for the abuse more appropriately. [U]	"Mike vented his rage at his parents and especially at his brothers whom he felt "ruined" him." (page 100)
25	If older male survivors become overwhelmed during therapy, by all the pain that resurfaces, the therapist may have to direct them to take a break from the memories. [U]	"There were times in our sessions when he felt overwhelmed by all the pain that was surfacing. I told him he could take a break from it. He drew a shade pulled down so he would not have to look at "all the miseries of my life". (page 101)
26	The goals of care for older adult survivors should include improving their coping skills and self-esteem. [C]	"Once a patient is identified as an incest survivor, goals for nursing care should include improving coping and self-esteem." (page 16)
26	Older adult survivors may have had limited opportunities to discuss their abuse experiences and so health professionals should encourage reminiscence and ventilation of their emotions.[C]	"The patient may have had limited opportunities to discuss the incest experience. Staff should encourage reminiscence and ventilation of emotions. " (page 16)
26	Health professionals should assess and build on past coping strategies, and focus on the elderly survivors strengths and encourage positive behaviours. [C]	"Past coping strategies should be assessed and built upon. Staff should focus on patient strengths and encourage positive behaviours." (page 16)
26	When an immediate stressor is identified, the health professional should provide crisis intervention or give the elderly survivor assistance with active problem solving. [C]	"... if an immediate stressor is identified, crisis intervention or assistance with active problem-solving may be provided by the nurse." (page 16)

Refers to the Paper or Text Number from **Master Table 1. The Master Table of Texts**, in Appendix I
[U] = Unequivocal – beyond reasonable doubt; [C] = Credible – plausible in light of the information

Findings

Categories

Antidepressants may provide some immediate symptom relief but they do not address or correct the negative beliefs and self-perceptions developed as a result of childhood abuse.

Health professionals need to assist older adult survivors to recognise that negative beliefs and self-perceptions can be the result of abusive childhoods, for which they are not responsible.

Health professionals should address low self-esteem and negative feelings resulting from childhood sexual abuse to minimise the possibility of continuing abuse, such as elder abuse.

The mainstay of treatment for unresolved childhood sexual abuse is the opportunity to share experiences, and to reflect on their effects throughout life and their meaning.

Psychotherapy may help older female survivors to connect their current problems with their childhood sexual abuse, and so facilitate more mature and reflective reasoning.

Based on a theoretical framework of Expanding Consciousness, nursing practice can shift the focus of care from the efficient completion of tasks to healing the whole person.

When health professionals understand the reasons for the older person's behaviour, then management becomes more straightforward.

Male health professionals who can use sexual transferences supportively and therapeutically can be effective in treating and enriching the lives of older women with very few males in their lives.

When dealing with "toxic" or very difficult older adults, health professionals must maintain a balance between caring involvement and professional detachment, be firm, and be able to apply tough love.

Termination of therapy may lead to feelings of anger and abandonment for the older female survivor.

Older female survivors may resist any reference to psychosocial problems or therapy during interactions with a therapist and prefer to consider them as "talks".

The failure of antidepressants to offer symptomatic relief should highlight the importance of addressing and correcting the negative beliefs of the older adult survivor.

Therapists may need to educate older male survivors about the behaviours commonly observed in sexually abused children, including hyper-sexuality with sexual acting-out and re-victimisation.

Older male survivor's ability to express anger at those who hurt them may be viewed as a positive indicator that they have relinquished some of the blame.

While older male survivors may resolve many of the issues around their own sexual abuse, the focal point of therapy may become the more difficult issue of guilt over their sexual abuse of a sibling.

Adult survivor's adherence to cancer treatment may be improved by containment of intense affect and distressing thoughts rather than exploration of them.

Older adult survivors with cancer can be helped to make a choice to focus on physical recovery, without either denying or ignoring their history of childhood sexual abuse.

2.4 Principles of Therapeutic Management

Part 1 of 3

Findings

If an older male survivor is also a child abuser, then to protect the public from possible risk, appropriate agencies may have to be involved in special "at risk" meetings.

The aim of therapy with older female survivors is to empower them to reclaim control over their lives.

Challenging lifelong defence mechanisms, accessing remote memory, confronting absent perpetrators and preserving self-empowerment in older female survivors are important tasks for both client and therapist.

In work with survivors of all ages it is important for health professionals to minimise the possibility of producing false memories of abuse by remaining as neutral as possible when exploring contextual clues.

Health professionals need to focus on a more realistic individualised "good enough" death for those older survivors with cancer who have chronic affect and relational instability, and for whom idealised expectations may lead to unwinnable struggles for control of distress.

Resolution is not always the only goal of professional intervention, there may be need for a range of changing goals; from resolution to palliation, to help older adult survivors to progress through their grieving process.

While the goals of treatment and care might need to change as dementia progresses, the core goals remain the same; to realise the individuality of the person to enable them to trust and feel trusted and to feel safe.

If aware of the history of attachments and losses of people with dementia, behaviours and emotions such as fear, anxiety, anger, restlessness may be understood and responded to appropriately.

Palliative treatment in dementia, aims to bring comfort by providing moments of overt happiness, contentment, meaningful relationships, maximum orientation, alertness & participation in meaningful activities.

Health professionals should evaluate complicated sibling dynamics, which may include childhood sexual abuse issues, when assessing an older person's care giving support system before judging the situation.

The primary role is to be comfortable with the silence surrounding disclosure of abuse and then proceed slowly at the older survivor's pace.

Health professionals may have to slow the pace of older female survivors' revelations so that the woman is not left feeling too vulnerable, and in turn, repress their feelings in future sessions.

Evaluation must be an ongoing process, adjustments can be made to the treatment plan as required, in conjunction with plans for termination.

The vehicle that allowed the older female to disclose her abuse; such as the Oprah Show, may be used to normalise survivor's feelings, pointing out the many women with similar feelings of inadequacy.

Health professionals can teach older female survivors self-care; exercises building self-esteem and how to identify and manage physical and mental health problems and make sensible personal decisions.

Through caring and empathy, health professionals can help older female survivors to differentiate between current distressing experiences and childhood sexual abuse, and come to accept the caring of others.

Health professionals should focus on their strengths; their thoughts, feelings, accomplishments and contributions, rather than the loss of capacity, frail physicality, recent dependencies and losses.

Categories

2.4 Principles of Therapeutic Management

Part 2 of 3

Findings

Categories

Older adult survivors may not be seen in therapy as often as desirable because of monetary constraints necessitating a more supportive approach to treatment.

Health professionals can respond sensitively, knowledgeably and proactively to difficult behaviour if shared knowledge gives the capacity to predict states and triggers of autonomic and emotional arousal.

Health professionals can create conditions where older female survivors feels safe to learn and develop, when they move on from diagnosing behaviours to understanding what the person is possibly going through.

Health professionals need to affirm and reaffirm that older female survivors expressing 'difficult' behaviours, are not children but mature people with good resources, who are often scared.

Dichotomy between 'successful ageing' and 'mental health problems' is not helpful when dealing with older survivors with severe disturbances, rather, health professionals should recognise the courage needed to endure the intense fear and despair they are obviously suffering.

Proceed at the older female survivor's pace, even when they seem to be 'getting better', because at this time there may be pressure to 'get better', and so control may be taken away and they may relapse.

Family issues may surface during care, it is important to secure confidentiality for the survivor while providing support for their family.

Health professionals do not have to 'cure' older female survivors rather, the aim should be to improve their quality of life.

Issues of 'termination' are important in psychological work and health professionals need to be aware of this from the beginning, especially when loss is such an important part of working with older people.

The conventional aim of psychotherapy, to lower defences, expose the pain and work through it, may be inappropriate for severely traumatised older adult survivors, rather, the aim may be supportive, where safety is established and the survivor helped to maintain control.

The foundation of work with older adult survivors must be based on an understanding of what it is to be 'strong at the broken places' and to promote their wisdom, ego-integrity and self-worth.

During therapy, older male survivors may vent their anger at the abusers and their parents, and apportion blame for the abuse more appropriately.

If older male survivors become overwhelmed during therapy, by all the pain that resurfaces, the therapist may have to direct them to take a break from the memories.

The goals of care for older adult survivors should include improving their coping skills and self-esteem.

Older adult survivors may have had limited opportunities to discuss their abuse experiences and so health professionals should encourage reminiscence and ventilation of their emotions.

Health professionals should assess and build on past coping strategies, focus on elderly survivors strengths and encourage positive behaviours.

When an immediate stressor is identified, health professionals should provide crisis intervention or give assistance with active problem solving.

2.4 Principles of Therapeutic Management

Part 3 of 3

NOTARI-View 2.4 - Synthesis 2: Category 4 – Principles of Therapeutic Management
(Health Professionals' Experiences with Older Adult Survivors: A Systematic Review of Text and Opinion)
Adapted from the NOTARI-View diagrams output from the NOTARI Module of JBI-CReMS

2.5 OPTIMISED THERAPEUTIC INTERVENTIONS

A Toolbox of Therapies and Techniques – Adapting, Innovating

The majority of authors represented in this Systematic Review are from psychology and social work backgrounds (Master Table 1. Appendix I) and many of the older adult survivors have been referred or self-referred specifically for psychological management (Relational Table 1.4 The Presentations and Problems, in Appendix I). There is little or no discussion of interventions to help older adult survivors with unresolved issues related to their childhood abuse at the primary level, for instance by general practitioners or community nurses.

2.5.1 *Determining the Optimal Therapeutic Approach*

Colarusso emphasises, albeit in relation to the complex cases that he examined, that the *"... choice of an optimal therapeutic approach is difficult in the absence of systematic treatment outcome data for such complex cases"*.⁴⁷

2.5.2 *Managing in the Current Therapeutic Setting*

Capasso suggests that while primary health professionals may facilitate healing by referring to appropriate therapists, if older adult survivors are not ready to talk with others, the most appropriate care may be to support the older person safely and non-judgementally in their current therapeutic environment.⁶⁴

2.5.3 *Using a Toolbox of Therapies and Techniques*

2.5.3.1 *Determined by the Theoretical Disposition of the Therapist*

A variety of psychotherapeutic interventions have been used, or proposed, to manage the problems faced by the older adult survivors described in the texts (Relational Table 1.5 The Treatments and Therapies, in Appendix I). Often the type of therapy was determined by the theoretical disposition of the therapist that the older adult survivor encountered. Colarusso (writing in a book on the psychoanalytic study of the child) proposes that for the female survivors of clerical abuse that he assessed *"...the entire theoretical basis of the therapeutic intervention would be psychoanalytic, both theoretically and technically. In particular, transference would be a major focus of the interaction between patient and therapist"*.⁴⁷ Crose, like Colarusso, examined older adult survivors from a developmental perspective,

but suggested Life Review Therapy as the therapeutic method that could help older clients to achieve the late life task of “ego integrity” [Erikson, 1963] by avoiding “*despair about past failures, regrets, indiscretions, and missed opportunities*”.⁵⁹

2.5.3.2 Different Therapies for Different Purposes

Other types of psychotherapy or counselling identified include Reminiscence Therapy,⁵¹ Cognitive Behavioural Therapies,^{45, 47, 48} Individual Systemic Therapy,⁴³ Psychodynamic Therapies,⁵⁶ Emotionally Focused Couple Therapy⁶⁷ and psychoanalytically based Art Therapy.⁶⁹

These different therapies were usually employed for specific purposes. Reminiscence Therapy was used to help integrate the positive and negative aspects of the older female survivors’ lives.⁴⁶ Cognitive therapeutic approaches were implemented to increase older adult survivors’ self-esteem and self-efficacy.⁴⁸ Art therapy was seen as a more “*congenial way*” for an older male survivor, more used to action than talk, to express himself and gain insight into his anger and low self-esteem.⁶⁹ When older adult survivors have posttraumatic symptoms, Colarusso suggests that in addition to “... *more traditional psychodynamic/psychoanalytic approaches, there are also approaches, such as, Trauma-focused Cognitive Behavioural Therapy/Dialectical Behavioural Therapy, that combine the development of organizing/clarifying narratives with development of improved posttraumatic self/affect/neurophysiologic regulation*”.⁴⁷

2.5.3.3 Different Techniques

As well as specific therapies, older adult survivors were introduced to techniques such as assertiveness training to manage anger adaptively,⁴⁸ self-comforting and containment skills such as diaphragmatic breathing, coping statements, thought stopping, journaling and guided visualisation⁴⁹ and self-care⁵¹ and self-protective strategies.⁴⁸

2.5.3.4 Different Modalities

While most interventions were individual sessions, couple counselling⁶⁷ and group modalities including referral to outside adult survivor support groups⁴⁶ were also employed. Often a variety of therapies and techniques were used at the same time, including “...*music and art therapy, bibliography, and in-depth discussions about the impact of childhood*

sexual abuse on self-concept".⁴⁶ A variety of therapies may have also been used over time as the response to each was evaluated and found to be not working, or to have been successful, so that the focus now moved to a more difficult problem.⁴⁸

2.5.3.5 In Dementia: Matching Goals and Methods

Miesen and Jones state that therapies and techniques such as "*...dynamic psychotherapy, reality orientation, reminiscence work, structured life review, validation therapy, music therapy, psychomotor therapy and so on may all be appropriate, either singly or in varying combinations*" to help treat people with dementia.⁶⁰ While many of these same methods may be used throughout the care of older adult survivors with dementia, the goals may change as the person becomes more impaired, moving from resolution to comfort and support.

2.5.4 Adapting Conventional Therapies

2.5.4.1 Pragmatic Considerations

It may be necessary to modify conventional therapies for use with older adult survivors. Some of the adaptations may be for pragmatic reasons, for instance because of the length of time since the abuse. McInnes-Dittrich illustrates how Life Review Therapy can be adapted to use symbolic confrontation to address family of origin issues when the perpetrator and enabler are both dead.⁵⁰

2.5.4.2 Gender Dynamics

Adaptations may also be necessary to address gender dynamics, for instance the use of props and non-verbal techniques like drawing, music therapy and journaling, to assist older female survivors, who may have been socialised to deny strong negative emotions, to express their anger and rage.⁵⁰

2.5.4.3 Cohort Issues

Allers and colleagues also suggest that to develop appropriate and effective services for older adult survivors, cohort issues; such as the stigma older cohorts attach to psychological assistance and their discomfort discussing sexual matters, need to be addressed.⁴⁶

2.5.4.4 Age and Socioeconomic Issues

Further, Allers and colleagues suggest that while older adult survivors may have more time flexibility, services need to be sensitive to age and socioeconomic status that may limit independence because of physical illness, frailty or even issues related to unresolved abuse.⁴⁶ This may require the provision of practical assistance such as transport, or in-home services that are low or no-cost.^{46, 51}

2.5.5 A Multidisciplinary Approach and Team Understanding

Sarkar describes how an innovative model of care; to manage an older female survivor with very complex needs; focused on “... a team understanding as opposed to the understanding of one ‘special’ therapist, within an easy to understand, simple, flexible and responsive approach that did not burden clinicians and patient with ‘heavy’ theory and technical jargon, thus making it ‘user friendly’”.⁶⁶ McLean and colleagues also found that modified Emotionally Focused Couple Therapy combined with a multidisciplinary approach, potentially improved the quality of life of an older female survivor and her husband during the last stages of her life and death with cancer.⁶⁷

2.5.6 Expanding Existing Services and Creating New Services

Allers and colleagues state that it may be necessary to create new services or expand existing ones to provide for the needs of older adult survivors. They suggest the need for support groups, crisis lines and community education programs to help older adult survivors to learn and to work through their unresolved issues.⁴⁶

2.5.4 Experimenting

Davenport suggests that traditional counselling or psychotherapy may be counterproductive when dealing with very difficult, or ‘toxic’, older adults because they will resist and block most efforts to help, so that it is important to find and treat the co-victim, usually a son or daughter.⁶¹ Davenport also suggests that these older adults will emotionally challenge service providers whose job it “...is to experiment until techniques are found that work for the agers, yourself, your personality, and the personality and degree of disintegration of the toxic agers being dealt with”.⁶¹

2.5.7 Pharmacotherapy

While there is some mention of pharmacotherapy in the texts, using anti-anxiety or antidepressant medication^{43, 45, 47, 49, 63} or antipsychotics,⁴⁴ these were generally used in conjunction with some form of psychotherapy.

Past pharmacotherapy by older adult survivors was often not very effective in minimising symptoms such as those of depression, and usually not evaluated for efficacy^{46, 48, 67} (Relational Table 1.5 The Treatments and Therapies in Appendix I).

Table 2.5 Optimised Therapeutic Interventions <i>Findings that make up this Category and Illustrations from the Texts</i>		
#	Finding	Illustration from Text
1	Creating new services or expanding existing programs can provide the information and emotional support needed by older adult survivors to work through their unresolved issues. [C]	"Creating new services or expanding existing programs (i.e. support groups, crisis lines) and launching community education campaigns can provide the information and emotional support needed by older survivors to work through their unresolved issues." (Page 16)
1	Counselling for depression in older female survivors may consist of a variety of therapies including music and art therapy, bibliography, and in-depth discussions about the impact of childhood sexual abuse on self-concept. [C]	"In response to the older client's symptoms of depression, counseling consisted of music and art therapy, bibliotherapy, and in-depth discussions regarding the impact that the unresolved childhood abuse had on her self-concept." (page 15)
1	To develop appropriate and effective services for older survivors, organisations need to recognise that while older people may have more time flexibility, they have particular problems with existing services for younger adults, such as underutilisation of counselling services, discomfort discussing sexual issues, physical frailty and psychosocial stressors.[C]	".. organizations currently providing assistance to adolescent and younger adult survivors of childhood abuse must learn about the problems (i.e. underutilization of counselling services, discomfort with discussing sexual issues, physical illness, psychosocial stressors) and strengths (i.e. time flexibility) of aged persons to develop appropriate and effective services for older survivors." (page 16)
1	Services offered to older adult survivors, especially with limited independence, need to be particularly sensitive to age and socioeconomic status so that they minimise the stigma felt by older adults towards psychological assistance, provide transportation or in-home services and offer programs that are low or no-cost. [C]	".. the potential for unresolved abuse to limit independence in older adulthood warrants the development of services that are particularly sensitive to socioeconomic status and age (i.e. services minimizing the stigma of psychological assistance, providing transportation or in-home services, offering low or no-cost programs)." (page 16)
1	Older female survivors may need to be referred to female therapists for individual psychotherapy and to adult survivor support groups. [U]	"Upon disclosing her history of childhood sexual abuse, the client was referred to an adult survivor support group and to a female therapist for individual psychotherapy." (page 15)

5	Sexual problems in older adults, derived from childhood sexual trauma, may require intensive individual therapy combining psychotherapy and sexual therapy. [C]	"The problems [sexual] deriving from earlier traumatic life experiences demand longer and deeper individual treatment, including a combination of psychotherapy and sexual therapy." (page 32)
7	Primary health professionals may facilitate healing by referring to appropriate therapists, but if older adult survivors are not ready to talk with others, the most appropriate care may be to support them safely and non-judgementally in their current therapeutic setting.[C]	"If the patient chooses to be healed, the CNS may collaborate with the primary home care nurse to facilitate further a path to healing by recommending therapists with whom the patient can talk.if the patient is not ready to talk with others, the most appropriate care may be to simply create an accepting and non-judgemental environment in which the patient's privacy and safety are assured." (page 229)
8	The entire theoretical basis of therapeutic intervention for older female survivors of abuse by the clergy, who have never received any treatment, would be psychoanalytic. [C]	"However, the entire theoretical basis of the therapeutic intervention would be psychoanalytic, both theoretically and technically. In particular, transference would be a major focus of the interaction between patient and therapist." (page 347)
8	In addition to traditional approaches, trauma based therapies such as Trauma-focused Cognitive Behavioural Therapy and Dialectical Behavioural therapy, may be appropriate for older female survivors abused by the clergy, who have chronic post-traumatic stress symptoms. [C]	"In addition to more traditional psychodynamic/psychoanalytic approaches, there are also approaches, such as, Trauma-focused Cognitive Behavioural Therapy/Dialectical Behavioural Therapy, that combine the development of organizing/clarifying narratives with development of improved posttraumatic self/affect/neurophysiologic regulation." (page 347)
9	Life Review is a valuable therapeutic method that can be used to help older clients to achieve the late life developmental task of ego integrity [Erikson, 1963] that enables them to avoid despair about past failures, regrets, indiscretions, and missed opportunities. [C]	"Achievement of "ego integrity" (Erikson, 1963) is the late life developmental task that enables the older person to avoid despair about past failures, regrets, indiscretions, and missed opportunities. Life review is a therapeutic method that helps older clients to achieve this late life developmental task." (page 66)
9	A sexual history, including sexual assault and abuse during earlier times in their lives, is an important part of life review for older women when addressing late life developmental issues. [C]	"Sexual concerns of women in therapy cover a wide range of issues, including ...recovery from sexual assault and abuse during earlier times in their lives" (page 64) "A sexual history is an important part of life review and should not be left out of this process for older women in therapy. (page 66)
10	Traditional counselling or psychotherapy is counterproductive when working with "toxic" or very difficult older adults because their resistance will block most efforts, but there is always a co-victim who if willing, can be taught coping and change strategies. [C]	"When working with toxic clients, traditional counselling or psychotherapy is counterproductive. ...The toxic's resistance and noncompliance will block most of your efforts. Find the co-Victim. There always is one. ...When the co-Victim is willing, teach him or her the coping and change strategies." (page 91)
10	Each "toxic" or very difficult older adult provides unique challenges, so it is important to experiment until techniques are found that work for all involved in this unique situation. [C]	"...each toxic ager is unique. Therefore, the job of service providers, and anyone challenged by these emotionally abusive agers, is to experiment until techniques are found that work for the agers, yourself, your personality, and the personality and degree of disintegration of the toxic agers being dealt with." (page 176)

12	Older female survivors may be treated with medication for depression and referred to a psychiatrist but may not keep appointments and be lost to follow up. [U]	"Because of depression, amitriptyline therapy was initiated. ... she was referred to a psychiatrist. She did not keep appointments and was lost to follow-up." (page 1050)
13	Cognitive therapeutic approaches may be implemented to increase older adult survivor's self-esteem and self-efficacy. [U]	"Cognitive approaches were implemented to increase the client's self-esteem and self-efficacy." (page 192)
13	During therapy the expression of anger may be encouraged, together with assertiveness training to teach older adult survivors how to express their anger adaptively. [U]	"Anger expressions were encouraged during sessions, and assertiveness training was utilized to teach the client how to express such anger adaptively." (page 192)
14	Adult survivors may feel less victimised by their cancer experience if they are taught effective self-comforting skills such as diaphragmatic breathing. [U]	"The acquisition of self-comforting skills helped CSA survivors feel less re-victimized by their cancer experience." (page 108) "Adaptive self comforting skills include but are not limited to diaphragmatic breathing, coping statements, thought stopping, journaling and guided visualization." (page 121)
14	Containment is an empathic response that can provide comfort and support when there is unexpected flooding of traumatic memories. [U]	"Containment is an empathic response to the unexpected flooding by traumatic memories and is a mechanism that provides comfort and support." (page 120)
16	Life Review Therapy with adaptations, like using non-verbal techniques and props, is a valuable tool in working with elderly female survivors. [C]	"With adaptations [props, non-verbal techniques], life review is a valuable tool in working with elderly female survivors of childhood sexual abuse." (page 172)
16	Symbolic confrontation may be effective for older adult survivors addressing family of origin issues where the perpetrators and enablers may be dead. [C]	"Frequently, survivors of childhood sexual abuse need to confront members of their family of origin in order to resolve their trauma. ... family-of-origin issues may be problematic, because the perpetrator and enablers may be deceased... in such cases, symbolic confrontation may effectively substitute for face-to-face confrontation." (page 170)
16	Non-verbal techniques such as drawing, music therapy and journaling, can be invaluable for older female survivors who have been socialised to deny strong negative feelings such as anger and rage. [C]	"For older women who have been socialized to deny strong negative feelings such as anger or rage, nonverbal techniques can be invaluable when incorporated into the life-review process." (page 169)
17	An appropriate couple-based intervention like modified Emotionally Focused Couple Therapy (EFT), and a multidisciplinary approach, has the potential to improve the quality of life, marital satisfaction and cohesion for older female survivors with cancer and their partners. [C]	"While the couple-based intervention [modified EFT] and multidisciplinary approach potentially contributed to this couple's quality of life, marital satisfaction and cohesion," (Page 231)
18	Interventions for care giving in dementia should fit the stage of the dementia with the same techniques used e.g. validation, reminiscence or music therapy, but with different goals e.g. comfort rather than resolution.	"The interventions for care-giving in dementia must fit the stage of the dementia process and the same techniques can be used for different goals." (page 152)

18	Techniques that can be used to help people with dementia such as dynamic psychotherapy, reality orientation, reminiscence work, structured life review, validation therapy, music therapy, psychomotor therapy and so on may all be appropriate, either singly or in varying combinations. [C]	"Techniques such as dynamic psychotherapy, reality orientation, reminiscence work, structured life review, validation therapy, music therapy, psychomotor therapy and so on may all be appropriate, either singly or in varying combinations." (page 152)
20	Health professionals need to be aware of community resources that provide low cost or free assistance for older adult survivors. [C]	"Social workers need to be aware of the many community resources that provide low cost or free assistance." (page 108)
20	Reminiscence therapy can help older female survivors to integrate the positive and negative aspects of their lives. [C]	"By using reminiscence therapy, the women were able to integrate the positive and negative aspects of their lives." (page 109)
23	The main focus of this innovative model for the management of RSH (repetitive self harm) in an older female survivor, stemmed from a team rather than one 'special' therapist understanding, within an easy to understand, simple, flexible and responsive approach that was 'user friendly'. [C]	"The main focus of management of RSH [Repetitive Self Harm] stemmed from a team understanding as opposed to the understanding of one 'special' therapist, within an easy to understand, simple, flexible and responsive approach that did not burden clinicians and patient with 'heavy' theory and technical jargon, thus making it 'use friendly'. (page 310)
25	Art therapy may be a more congenial way for older male survivors, more used to action than talk, to relate and express themselves and gain insight into their underlying anger and low self-esteem. [C]	"He was a man of action, rather than talk, whose one relief was woodworking. As a result, art therapy was a more congenial way of relating and expressing himself than simply talking. He was able to use art-making to gain insight into his anger and low self-esteem that grew out of his abusive background, and as a result, he made significant changes in his life. He felt no longer driven and could take advantage of his financial success to enjoy his life." (page 103-104)

Refers to the Paper or Text Number from **Master Table 1. The Master Table of Texts**, in Appendix I
[U] = Unequivocal – beyond reasonable doubt; [C] = Credible – plausible in light of the information

Findings

Creating new services or expanding existing programs can provide the information and emotional support needed by older adult survivors to work through their unresolved issues.

Counselling for depression in older female survivors may consist of a variety of therapies including music and art therapy, bibliotherapy, and in-depth discussions about the impact of the abuse on self-concept.

To develop appropriate and effective services for older survivors, organisations need to recognise while older people may have more time flexibility, they have particular problems with existing services for younger adults, e.g. underutilisation of counselling services, discomfort discussing sexual issues, physical frailty and psychosocial stressors.

Services offered to older adult survivors, especially with limited independence, need to be particularly sensitive to age and socioeconomic status so that they minimise the stigma felt by older adults towards psychological assistance, provide transportation or in-home services and offer programs that are low or no-cost.

Older female survivors may need to be referred to female therapists for individual psychotherapy and to adult survivor support groups.

Sexual problems in older adults, derived from childhood sexual trauma, may require intensive individual therapy combining psychotherapy and sexual therapy.

Primary health professionals may facilitate healing by referring to appropriate therapists, but if older adult survivors are not ready to talk with others, the most appropriate care may be to support them safely and non-judgementally in their current therapeutic setting.

The entire theoretical basis of therapeutic intervention for older female survivors of abuse by the clergy, who have never received any treatment, would be psychoanalytic.

In addition to traditional approaches, trauma based therapies such as Trauma-focused Cognitive Behavioural Therapy and Dialectical Behavioural therapy, may be appropriate for older female survivors who have chronic post-traumatic stress symptoms.

Life Review is a valuable therapeutic method that can be used to help older clients to achieve the late life developmental task of ego integrity (Erikson, 1963) that enables them to avoid despair about past failures, regrets, indiscretions, and missed opportunities.

A sexual history, including sexual assault and abuse during earlier times in their lives, is an important part of life review for older women when addressing late life developmental issues.

Traditional counselling or psychotherapy is counterproductive when working with 'toxic' or very difficult older adults because their resistance will block most efforts, but there is always a co-victim who if willing, can be taught coping and change strategies.

Each 'toxic' or very difficult older adult provides unique challenges, so it is important to experiment until techniques are found that work for all involved in this unique situation.

Older female survivors may be treated with medication for depression and referred to a psychiatrist but may not keep appointments and be lost to follow up.

Categories

2.5 Optimised Therapeutic Interventions

Part 1 of 2

Findings

Categories

Cognitive therapeutic approaches may be implemented to increase older adult survivor's self-esteem and self-efficacy.

During therapy the expression of anger may be encouraged, together with assertiveness training to teach older adult survivors how to express their anger adaptively.

Adult survivors may feel less victimised by their cancer experience if they are taught effective self-comforting skills such as diaphragmatic breathing.

Containment is an empathic response that can provide comfort and support when there is unexpected flooding of traumatic memories.

Life Review Therapy with adaptations, like using non-verbal techniques and props, is a valuable tool in working with elderly female survivors.

Symbolic confrontation may be effective for older adult survivors addressing family of origin issues where the perpetrators and enablers may be dead.

Non-verbal techniques such as drawing, music therapy and journaling, can be invaluable for older female survivors who have been socialised to deny strong negative feelings such as anger and rage.

An appropriate couple-based intervention like modified Emotionally Focused Couple Therapy (EFT), and a multidisciplinary approach, has the potential to improve the quality of life, marital satisfaction and cohesion for older female survivors with cancer and their partners.

Interventions for care giving in dementia should fit the stage of the dementia with the same techniques used e.g. validation, reminiscence or music therapy, but with different goals e.g. comfort rather than resolution.

Techniques that can help people with dementia such as dynamic psychotherapy, reality orientation, reminiscence work, structured life review, validation therapy, music therapy, psychomotor therapy and so on may all be appropriate, either singly or in varying combinations.

Health professionals need to be aware of community resources that provide low cost or free assistance for older adult survivors.

Reminiscence therapy can help older female survivors to integrate the positive and negative aspects of their lives.

Main focus of this innovative model for the management of repetitive self harm in an older female survivor, stemmed from a team rather than one 'special' therapist understanding, within an easy to understand, simple, flexible and responsive 'user friendly' approach.

Art therapy may be a more congenial way for older male survivors, more used to action than talk, to relate and express themselves and gain insight into their underlying anger and low self-esteem.

2.5 Optimised Therapeutic Interventions

Part 2 of 2

NOTARI-View 2.5 - Synthesis 2: Category 5 – Optimised Therapeutic Interventions

(Health Professionals' Experiences with Older Adult Survivors: A Systematic Review of Text and Opinion)

Adapted from the NOTARI-View diagrams output from the NOTARI Module of JBI-CReMS

2.6 RESEARCH: EVIDENCE TO GUIDE CARE

2.6.1 *A Clear Need for Information to Inform Practice*

As Colarusso says the “research challenges are many and daunting, but can be informed by clinical material, particularly the effect of childhood sexual abuse on the developmental progression throughout the life cycle”.⁴⁷ He also states that without systematic treatment outcome data it is difficult to plan an optimal therapeutic approach.⁴⁷ Gallo Silver and Weiner also bemoan the paucity of research on adult survivors of childhood sexual abuse with cancer; beyond anecdotal information, and support the need for outcome research to facilitate the standardisation of effective psychosocial interventions, based on best clinical practice.⁴⁹ Miesen and Jones affirm the need for more research, both retrospective and longitudinal, to understand the best treatment for the different types and degrees of psychic pain experienced by people with dementia.⁶⁰ Walter suggests that there is a clear need for research to assess the prevalence and the symptomatology seen in later life, to inform the treatment of older adult survivors.⁶³

2.6.2 *A Lack of Data from Older Cohorts*

Walter, in 1992, stated that research into incest survivors had largely been limited to younger populations, possibly because of the relative unavailability of older survivors, disinterest in older cohorts and/or the stigma attached to this type of abuse, especially in the elderly.⁶³ Altschuler and Katz, in 2010, suggest that little has changed when they assert that “denial and feelings of shame associated with incest conspire with invisibility of sexuality with age to make documented incest experiences and data non-existent or rare, among elderly women”.⁶²

2.6.3 *Longitudinal Research Paradigms Should Include Older Adults and Late-Life Issues*

Several authors state that research should examine the longitudinal effects of childhood sexual abuse, and include older adult survivors in research paradigms.^{46, 48} Gagnon and Hersen also propose that research should “...examine the potential effects that age-related stressors and developmental tasks have on late-life functioning”.⁴⁸ In a similar vein, Allers

and colleagues suggest that research is needed to understand “...the specific behaviors and dynamics associated with older adult survivors”.⁴⁶

2.6.4 A Need to Evaluate Innovative and Pilot Models of Care

Miesen and Jones assert that critical evaluations of pilot therapies for people with dementia are much needed,⁶⁰ while Sarkar agrees that innovative, pilot models of care need to be evaluated beyond the pilot stage, for both genders and in different clinical settings.⁶⁶

2.6.5 Suggestions for Additional Research

- Research is needed to understand the links between Posttraumatic Stress Disorders and needs based behaviours in people with dementia.⁶⁰
- Research is needed into the relationship between childhood sexual abuse and the development of conversion disorders in older age.⁴⁵
- There is a need to develop management standards for self-harming behaviour beyond locally developed protocols.⁶⁶

Table 2.6 Research: Evidence to Guide Care*Findings that make up this Category and Illustrations from the Texts*

#	Finding	Illustration from Text
1	Research is needed to understand the specific behaviours and dynamics associated with older adult survivors of childhood sexual abuse. [U]	"As members of the mental health profession become familiar with childhood abuse and its long-term effects on aging, additional research will be needed to understand the specific behaviors and dynamics associated with older adult survivors. (page 16)
1	Researchers should examine the longitudinal effects of abuse and include older adult participants in research paradigms. [U]	"Future researchers should examine the longitudinal effects of abuse and include older adult participants in research paradigms." (page 16)
2	Information about the experiences of older female survivors is rare because of their denial and feelings of shame together with the invisibility of sexuality in the aged. [U]	"Denial and feelings of shame associated with incest conspire with invisibility of sexuality with age to make documented incest experiences and data non-existent or rare, among elderly women." (page 52)
8	In the absence of systematic treatment outcome data for such complex cases involving older female survivors of clerical abuse, the choice of an optimal therapeutic approach is difficult. [U]	"The choice of an optimal therapeutic approach is difficult in the absence of systematic treatment outcome data for such complex cases." (page 347)
8	Research challenges are many and daunting, but can be informed by clinical material, particularly the effect of child sexual abuse on developmental progression throughout the life cycle. [C]	"The research challenges ... are many and daunting. Hopefully, this clinical material will contribute to our knowledge, particularly of the effect of child sexual abuse on developmental progression throughout the life cycle, and to our ability to help." (page 349)
12	The relationship between childhood sexual abuse and the development of a conversion disorder such as psychogenic seizures in old age has not been studied. [U]	"The relation between sexual abuse in childhood and development of psychogenic seizures in old age has not been studied." (page 1051)
13	Research is needed to address the life course patterning of unresolved childhood sexual abuse and should include older subjects and examine potential effects that age related stressors and developmental tasks have on late life functioning. [U]	"Research is needed to address the life-course patterning of unresolved CSA. Future research should investigate the longitudinal effects of CSA, and older subjects obviously should be included in such research paradigms. Specifically, such investigations should be undertaken to examine potential effects that age-related stressors and developmental tasks have on late-life functioning." (page 196)
14	The paucity of research on survivors of childhood sexual abuse with cancer needs to be addressed to learn more about their needs and concerns beyond anecdotal information. [U]	"The paucity of research on survivors of CSA with cancer needs to be addressed to learn more about their needs and concerns beyond anecdotal information." (page 127)

14	Research is needed to measure the efficacy of psychosocial interventions, to develop best clinical practice for the psychosocial care of survivors of childhood sexual abuse with cancer. [U]	"Additional research is needed to measure the efficacy of the psychosocial interventions. This could facilitate the standardization of effective interventions and the development of best clinical practice for the psychosocial care of survivors of CSA with cancer." (page 127)
18	More research, both retrospective and longitudinal, is needed to understand the best treatment modalities for the different types and degrees of psychic pain experienced by people with a dementing illness. [U]	"... if we are to find a way to match the types and degree of psychic pain to the best treatment modality, we need more research of both a retrospective and longitudinal nature." (page 152)
18	Evaluations of pilot therapies for people with dementia are critically needed. [U]	"Critical evaluations of pilot therapies have in the past been lacking, yet are much needed." (page 152)
18	Research is needed to understand the links between Post-Traumatic-Stress Disorders and needs based behaviours in persons with dementia. [U]	"Links with Post-Traumatic Stress Disorders, using both literature and clinical experiences, need to be established with behaviour in dementia." (page 152)
23	New innovative models of care need to be evaluated beyond the pilot stage, for both genders and in different clinical settings.[U]	"However, for this model to be considered effective for this subgroup of patients, it requires further exploration and use with a series of patients of both genders, in different clinical settings." (page 310)
23	There is a need to develop management standards for repetitive Self Harm behaviours beyond locally developed protocols. [U]	"RSH [Repetitive Self Harm] is a behaviour and not an illness, there are no accepted standards for its management that exist beyond locally developed protocols." (page 302)
26	Research into incest survivors has largely been limited to the younger population for various reasons, probably related to the relative unavailability of the elderly, disinterest in older cohorts, and/or the stigma associated with this type of victimisation. [C]	"It appears that researchers have limited the study of incest survival to younger populations. Perhaps this is related to a relative unavailability of the elderly, disinterest in older cohorts, or the stigma associated with this type of victimization." (page 15)
26	There is a clear need for research to assess the prevalence, the symptomatology seen in later life, and the treatment of older adult survivors of incest. [U]	"There is a clear need for research that will assess prevalence, late life symptomatology, and treatment of elderly survivors of incest." (page 16)

Refers to the Paper or Text Number from **Master Table 1. The Master Table of Texts**, in Appendix I
[U] = Unequivocal – beyond reasonable doubt; [C] = Credible – plausible in light of the information

Findings

Categories

Research is needed to understand the specific behaviours & dynamics associated with older adult survivors of childhood sexual abuse.

Researchers should examine the longitudinal effects of abuse and include older adult participants in research paradigms.

Information about the experiences of older female survivors is rare because of their denial and feelings of shame together with the invisibility of sexuality in the aged.

In the absence of systematic treatment outcome data for such complex cases involving older female survivors of clerical abuse, the choice of an optimal therapeutic approach is difficult.

Research challenges are many and daunting, but can be informed by clinical material, particularly the effect of child sexual abuse on developmental progression throughout the life cycle.

The relationship between childhood sexual abuse and the development of a conversion disorders such as psychogenic seizures in old age has not been studied.

Research is needed to address the life course patterning of unresolved childhood sexual abuse and should include older subjects and examine potential effects that age related stressors and developmental tasks have on late life functioning.

The paucity of research on survivors of childhood sexual abuse with cancer needs to be addressed to learn more about their needs and concerns beyond anecdotal information.

Research is needed to measure the efficacy of psychosocial interventions, to develop best clinical practice for the psychosocial care of survivors of childhood sexual abuse with cancer.

More research, both retrospective and longitudinal, is needed to understand the best treatment modalities for the different types and degrees of psychic pain experienced by people with a dementing illness.

Evaluations of pilot therapies for people with dementia are critically needed.

Research is needed to understand the links between Post-Traumatic Stress Disorders and needs based behaviours in persons with dementia.

New innovative models of care need to be evaluated beyond the pilot stage, for both genders and in different clinical settings.

There is a need to develop management standards for repetitive Self Harm behaviours beyond locally developed protocols.

Research into incest survivors has largely been limited to the younger population for various reasons, probably related to the relative unavailability of the elderly, disinterest in older cohorts, and/or the stigma associated with this type of victimisation.

There is a clear need for research to assess the prevalence, the symptomatology seen in later life, and the treatment of older adult survivors of incest.

2.6 Research

NOTARI-View 2.6 - Synthesis 2: Category 6 – Research: Evidence to Guide Care
(Health Professionals' Experiences with Older Adult Survivors: A Systematic Review of Text and Opinion)
Adapted from the NOTARI-View diagrams output from the NOTARI Module of JBI-CReMS

Discussion: Conclusions and Implications

Conclusions

This systematic review of text and opinion uncovered a rich vein of information on the experiences of health professionals with older adults sexually abused as children; and while the information may be particular to the cases described, it draws on a wide range of professional opinion and the synthesised findings can be used to inform clinical practice.

Unfortunately there is almost a total lack of empirical research data of any type or any quality to guide therapeutic care for older adult survivors based on best clinical practice. There is a clear need for research of all types, longitudinal and retrospective, to understand prevalence, symptomatology and best treatment options. There is a particular need to understand the types and degrees of distress expressed by older adult survivors with dementia.

The 38 survivors' stories demonstrate that older adult survivors can be helped and can change at any age (see Relational Table 1.6 The Outcomes of Interventions in Appendix I). Even if resolution is not possible, the older person's quality of life can be improved in many cases. This highlights the importance of health professionals acting to help even the very old, the dementing and the dying to find some release from distress that may be related to sexual abuse in childhood.

The first synthesised finding highlights the need for health professionals at all levels, who are involved in the care of older adults, to understand the current problems of their older clients in context, which may include understanding the impact of sexual abuse in childhood and its dynamic consequences across the entire life course into older age.

The problems exhibited by older adults may not just be the result of ageing but may have origins in earlier sexual abuse, decades before in childhood. The attitudes of this older cohort can affect their health seeking behaviours, maintaining their silence, and making medical rather than mental health care more acceptable to them. Additionally, the changes and losses that can occur in older age may be implicated in the return or exacerbation of unresolved childhood sexual abuse issues.

The second synthesised finding asserts that health professionals should use their understanding of the effects of childhood sexual abuse across the life course, to assist in the identification of older clients who may be survivors of childhood sexual abuse. Health professionals with this understanding, together with appropriate values and attitudes, should then act effectively and safely to guide care. It may be particularly important for health professionals to enquire about the abuse history of older clients presenting with chronic affect disorders or substance abuse.

While health professionals with appropriate knowledge and experience, and values and attitudes, can effectively guide care, they also need ongoing support from their peers and from supervision to maintain their effectiveness. In the residential care setting, ongoing management of residents with disturbed even violent behaviour can demoralize staff and lead to excessive burnout and staff sickness. In these settings, care staff need to have their distress validated. While containment of strong emotions may be necessary for residents, the health professionals caring for them also need their own containment strategies.

Finally, health professionals must continue to learn, grow and develop regardless of their years of experience and expertise.

Implications for practice

The Joanna Briggs Institute as stated in their Reviewers' Manual (pages 135-137)⁴² require that each systematic review conducted under its umbrella contains implications or recommendations for practice that are constructed using a common approach. The Joanna Briggs Institute require that the recommendations are drawn from the results of the reviews alone; not the reviewer's opinion, and given a level of evidence based on the nature of the research; or in the case of this systematic review, the text and expert opinion used to inform the development of the recommendation. The Joanna Briggs Institute Levels of Evidence range from 1 for the highest level, such as a Meta-synthesis of research with unequivocal synthesised findings to 4, the lowest level for a single expert opinion paper.

All of the following recommendations for practice have a Level of Evidence of 3 because they have arisen from a Meta-synthesis of text and opinion with Credible synthesised findings. The authors of the texts and the themes and conclusions extracted by the reviewer have been assessed during the systematic review process to be credible.

The Joanna Briggs Institute states that in, *"...text and opinion reviews, recommendations are declamatory statements that are steeped in context, therefore generalisability occurs between cases rather than across broad populations"*.⁴² The following recommendations cannot be generalised or prescriptive and so the declamatory statements will at best be tentative so that health professionals, researchers and policy makers who make use of the recommendations should do so with reference to the extant literature and available clinical expertise. However, in the relative absence of quantitative or qualitative evidence of any quality to guide care of older adult survivors, the synthesised findings of this systematic review provide a valid starting point to the systematic determination of optimal therapeutic approaches. The current recommendations may be expanded, adapted, amended or even discarded over time if health professionals and researchers have the will to do so. [For a more extensive understanding of the following recommendations please refer to the Findings in the Results Section].

The First Synthesised Finding: Health professionals, at all levels, who are involved in the care of older adults, need to understand their clients in context; how the problems they currently experience may be related to sexual abuse in childhood and the dynamic consequences of that abuse across the older person's entire life course.

The implications for practice arising from the First Synthesised Finding are related to the education of all health professionals who encounter older adults to be able to understand the life course consequences of childhood sexual abuse and how it may manifest in their older client population. At an individual clinical level, health professionals should be able to use this knowledge to help them identify older adult survivors and to guide their care.

Recommendation 1

Health professionals involved in the care of older adults should be educated about how the problems currently experienced by their older clients may be related to sexual abuse in childhood and the dynamic consequences of that abuse across the older person's entire life course.

This relates to how the problems suffered by older adults are not necessarily the result of aging; although they may be reactivated or exacerbated by the losses and changes likely to occur in older age, but may have their origins in earlier times; even with sexual abuse in childhood and its repercussions across the entire life course.

Recommendation 1.1

Health professionals should be educated to understand how the basic values and attitudes of the older adult survivor's birth cohort can influence their health behaviours, even into older age.

This relates to how the interplay of human life and historical time in early life, has influenced the basic values, attitudes and even abuse constructs over the lifespan of these older adult survivors, reinforcing their relative and absolute silence and continuing to influence the choices they make in older age, especially their choices to seek and accept help, and their

relationships with health professionals usually born in an era with values somewhat different to their own.

Recommendation 1.2

Health professionals should be educated to understand how historical and cultural changes, may continue to influence the health behaviours of survivors into older age.

This refers to how the influence of the mass media and a more supportive society; including legislative changes, have empowered older adult survivors, especially women, to break their silence. Still many of these older adult survivors are slow to change, often resigning themselves to their 'lot', feeling more comfortable with medical models of treatment while being seen as unattractive and bothersome by many in society.

Recommendation 1.3

Health professionals should be educated to understand how life events and their timing, transitions and turning points, and risks and protective factors have resulted in vulnerabilities and resilience in older adult survivors that continue to affect them.

This refers to how early adverse life events such as childhood sexual abuse and the circumstances that made it possible, may have had a significant negative impact on the life course of older adult survivors. The processes set in train early, especially if the abuse was severe, can interact with future events to accumulate and cascade across the lifespan resulting in differential vulnerabilities, and also resilience, for survivors as they age.

Recommendation 1.4

Health professionals should be educated to understand how linked or interdependent lives have affected survivors and generations of their families, across their lifespan and continue to affect them into older age.

This refers to how individual lives are linked at all levels within and between families, generations, cultures and societies. These linkages can support, control or damage the individual or the larger unit. The older adult survivors represented have suffered initial damage and then later re-victimization, relationship problems and multi-generational

problems. Forming and sustaining healthy relationships is perhaps the main challenge faced by survivors throughout their life course into older age.

Recommendation 1.5

Health professionals should be educated to understand how the ability of survivors to make choices, as well as the choices they make, have affected them across their lifespan, continuing into older age.

This refers to how choices may be constrained by the effects of childhood sexual abuse so that the choices made, while providing some control of psychic distress at the time, may come at a terrible cost, such as “escape” to a lifetime of spousal abuse, a lifetime without children or the strengthening of maladaptive coping mechanisms such as substance abuse, self-harm, denial and dissociation. Older adult survivors may also make courageous choices to expose the abuser despite the personal cost.

Recommendation 1.6

Health professionals should be educated to understand how diverse and interacting life course trajectories have developed over the lifespan and continue to affect survivors into their older age.

This refers to how the life course trajectories for older adult survivors are unique, dynamic and to some extent damaged. Relational trajectories may have been the most damaged and consequently damaging to other aspects of older adult survivors’ lives. The behavioural life course trajectories of some older adult survivors may have been affected by substance abuse issues; including alcohol and prescription drug misuse and suicidal behaviour. Trajectories of silence may have been experienced to varying degrees by many older adult survivors, some never having told anyone of the abuse even during therapy. Even, apparently successful highly functioning older adult survivors may still feel inadequate.

The Second Synthesised Finding: Health professionals should use their understanding of the context of their older adult clients' lives; which may include sexual abuse during childhood, to identify past abuse and to guide care within a professional therapeutic alliance based on safety for both the older adult and the health professionals.

The implications for practice arising from the Second Synthesised Finding are related to the need for all health professionals who encounter older adults to be able to use their understanding of the life course consequences of childhood sexual abuse and how it may manifest in their older client population, to identify older adult survivors with unresolved issues, and then to act on that understanding to guide care within a professional therapeutic alliance.

Recommendation 2

Health professionals *should act on their understanding of the context of their older clients' lives; which may include sexual abuse in childhood, to identify past abuse and then to guide care within an optimised professional therapeutic alliance.*

This relates to the fundamental requirement for health professionals to act on the integrated, holistic understanding they should have gained about their older adult clients; who may be survivors of childhood sexual abuse. This action should occur within a therapeutic alliance where the older adult survivor and the health professional both feel safe to explore the possibilities for healing in an individualised, flexible and optimised way, based on evidence and best-practice.

Recommendation 2.1

Health professionals should, above all, ensure physical and psychological safety for their older adult clients; who may be survivors of childhood sexual abuse, and also for themselves.

This refers to the overarching requirement for the interaction between older adult survivors and health professionals; be it at a general level of care or at a specialist mental health level, to be conducted in an environment of physical and psychological safety. While it is important to provide a safe place for older adult survivors to be vulnerable and to heal, this is not possible unless health professionals also feel safe. Of special note is the need for staff in residential care settings to receive adequate support to validate their distress.

Recommendation 2.2

Health professionals should ensure that they have appropriate expertise and knowledge, and values and attitudes, to professionally and ethically manage the care of their older adult clients; who may be survivors of childhood sexual abuse.

This refers to how health professionals in all fields and levels of practice, who may encounter older adult survivors, need to have knowledge about the consequences of childhood sexual abuse and that challenges the myths that suggest that all limits in cognitive and emotional functioning are the result of 'normal aging'. They also need the knowledge and skills (dependent on their scope of practice) as well as the self-awareness and values and attitudes to ensure that they do not consciously or unconsciously misguide the direction of therapy.

Recommendation 2.3

Health professionals should have the knowledge to be able to identify problems in their older clients that are possibly related to sexual abuse in childhood, and the skills to know if, when, and how, to facilitate disclosure.

This refers to how health professionals involved in the care of older adults should be educated to recognise the often disguised and complex signals that may indicate unresolved issues related to childhood sexual abuse

This also refers to how disclosure of the abuse should be individually timed and paced with consideration given to the physical health and resilience of the older adult survivor. Health professionals should understand how ‘challenging behaviours’ by older adults in residential care may make sense in terms of the long-term effects of past abuse.

Recommendation 2.4

Health professionals should base their therapeutic management on principles where the goals and the focus are dynamic, and matched to needs, and where therapy is evaluated and eventually ended, all under an umbrella of safety.

While older adult survivors are such a diverse group that no single model of care is appropriate, this recommendation refers to how there are certain principles of care that health professionals should consider when developing a management plan, for instance any model of care needs to be holistic and built on a therapeutic foundation of safety with ongoing evaluation and planning for termination. Goals may also need to change, for instance from healing to support, in the older adult survivor with dementia. Focus may also change as therapy progresses and some issues are resolved or others become more pressing.

Recommendation 2.5

Health professionals should be able to provide optimised therapeutic interventions based on a toolbox of conventional, modified or newly created therapies, techniques and modalities.

This refers to how, despite the absence of systematic treatment outcome data to choose an optimal therapeutic intervention, health professionals may need to use a variety of therapies, techniques and modalities for different purposes at different times. Conventional therapies may have to be adapted for pragmatic reasons, because of gender issues, cohort issues, socioeconomic or physical reasons. It may be necessary to create new services or expand existing ones to provide for the needs of older adult survivors. The primary health professional may even have to provide management if the older adult survivor does not choose to be referred. Additionally, innovative models of care should be developed and trialled by health professionals.

Implications for Research

The implications for research are related to the paucity of research relevant to older adult survivors and the call by many of the authors for this to be addressed, so that therapeutic interventions can be optimised.

Research Recommendation 1

There is a clear need for research of all types to inform the treatment of older adult survivors.

This refers to the paucity of research beyond anecdotal information that makes it difficult to provide older adult survivors with optimised therapeutic interventions based on best practice. There is a need to assess the prevalence and symptomatology seen in older adult survivors and to determine the best therapeutic approaches using research of all types; both retrospective and longitudinal, that can provide systematic treatment outcome data.

Research Recommendation 2

Health professionals and researchers need to understand the reasons that research about childhood sexual abuse, has largely ignored older adult populations.

This relates to how information on the experiences of older adult survivors is rare. This may be because of the relative unavailability of older survivors, disinterest in older cohorts by researchers or the stigma attached to this type of abuse; especially in the elderly.

Research Recommendation 3

Research should examine the longitudinal effects of childhood sexual abuse, and include older adult survivors in research paradigms.

This relates to how older adult survivors need to be understood through the lens of their entire life course and how late life stressors and developmental tasks of older age may come to affect their current functioning.

Research Recommendation 4

There is a critical need for pilot or innovative models of care that are developed by clinicians, to be systematically evaluated.

This relates to how new models of care that are being developed by clinicians, need to be taken further, beyond the pilot stage, which can only occur if they are rigorously evaluated in different clinical settings for different genders.

Research Recommendation 5

Health professionals and researchers should identify and examine additional areas of clinical concern related to older adult survivors.

This recommendation refers to additional suggestions made by several of the authors of the 26 texts included in the systematic review, including study of:

- *The relationship between childhood sexual abuse, Posttraumatic Stress Disorders and needs based behaviours in older adults with dementia.*
- *The relationship between childhood sexual abuse and the development of conversion disorders in older age.*
- *The development of management standards for self-harming behaviour beyond locally developed protocols.*

Conflicts of Interest

None identified.

APPENDICES

Appendix I - Relational tables

The tables included in this section are all related to the first table; Master Table 1. The Master Table of Texts (Included), by the # number that is a unique identifier for each of the papers and texts included in this systematic review. The tables originate from information in the 26 included papers and texts and are an adjunct to the Findings in the Results section.

The structure of the relationships between the tables is similar to that of a relational database, where one table can be related to many tables through unique identifying numbers.

Master Table 1. The Master Table of Texts (Included)				
Year	Author/s	Profession/s	Situated	Journal/Book
#1 Unresolved childhood sexual abuse: are older adults affected? 46				
1992	Allers, Christopher T. Benjack, Karen J. Allers, Norman T.	Psychotherapist Psychotherapist Methodist Minister	Atlanta, Georgia, USA	Journal of Counseling & Development
#2 Sexual secrets of older women: countertransference in clinical practice 57				
1996	Altschuler, Joanne Katz, Anne D.	Assistant Prof. Dept. Social Work Assistant Prof. of Clinical Gerontology	Los Angeles, CA, USA	Clinical Gerontologist
#3 Keeping your eye on the process: body image, older women, and countertransference 62				
2010	Altschuler, Joanne Katz, Anne D.	Professor School of Social Work Professor Clinical Gerontology	Los Angeles, CA, USA	Journal of Gerontological Social Work
#4 Sexuality in older women with mental health problems 43				
2002	Benbow, Susan M. Jagus, Chris E.	Consultant Psychiatrist Consultant Old Age Psychiatry	Wolverhampton UK	Sexual and Relationship Therapy
#5 Psycho-sexual therapy with elders (in Past Trauma in Late Life Ed. Hunt, L. et al) 56				
1997	Bergström-Walan, M.	Midwife, Psychologist, Psychotherapist PhD	Stockholm, Sweden	Past Trauma in Late Life – Chapter 3
#6 The organic and psychological antecedents of delusional jealousy in old age 44				
1994	Breitner, Barbara C. Anderson, David N.	Registrar in Psychiatry Consultant Psychogeriatrician	Liverpool, UK	International Journal of Geriatric Psychiatry
#7 The theory is the practice: an exemplar 64				
1998	Capasso, Virginia A.	Advanced Practice Nurse PhD	Boston, Mass. USA	Clinical Nurse Specialist
#8 The relentless past: the effect of chronic sexual abuse in childhood on fifty years of adolescent and adult development (in The Psychoanalytic Study of the Child Ed. King, R. A. et al) 47				
2009	Colarusso, Calvin A.	Clinical Professor of Psychiatry	San Diego, CA, USA	The Psychoanalytic Study of the Child – Ch. 64
#9 Addressing late life developmental issues for women: body image, sexuality, and intimacy (in Handbook of Counseling and Psychotherapy with Older Adults Ed. Duffy, Michael) 59				
1999	Cröse, Royda G.	Professor of Gerontology Psychologist	Muncie, Indiana, USA	Handbook of Counseling and Psychotherapy with Older Adults – Ch. 41
#10 Working with toxic older adults 61				
1999	Davenport, Gloria M.	PhD Counselor for Reentry Students and Older Adults – Retired	Santa Ana, College, CA, USA	Book – various Chapters

Master Table 1. The Master Table of Texts <i>(Included)</i>				
Year	Author/s	Profession/s	Situated	Journal/Book
#11 Impact of long term sexual abuse 70				
1986	Duenas, Maria T.	Psychologist Counselor	College of Notre Dame, Maryland, USA	Clinical Gerontologist
#12 Psychogenic seizures in old age: a case report 45				
1993	Fakhoury, Toufic Abou-Khalil, Bassel Newman, Karen	Neurologist Neurologist Psychiatrist	Vanderbilt Uni, Nashville, Tenn, USA	Epilepsia
#13 Unresolved childhood sexual abuse and older adults: late-life vulnerabilities 48				
2000	Gagnon, Michelle Hersen, Michel	Psychologist Prof. School Professional Psychology	Pacific Uni., Forest Grove, Oregon, USA	Journal of Clinical Geropsychology
#14 Survivors of childhood sexual abuse diagnosed with cancer: managing the impact of early trauma on cancer treatment 49				
2006	Gallo-Silver, Les Weiner, Michael O.	LCSW Director Clinical Programs LMSW Psychotherapist	CancerCare, New York, USA	Journal of Psychosocial Oncology
#15 The man who claimed to be a paedophile 65				
2000	Hill, Simon A.	Senior House Officer in Acute & Rehabilitation Psychiatry	St Lawrence's Hospital, Cornwall, UK	Journal of Medical Ethics
#16 Adapting life-review therapy for elderly female survivors of childhood sexual abuse 50				
1996	McInnes-Dittrich, Kathleen	Associate Professor Graduate School Social Work	Boston College, Chestnut Hill, Mass, USA	Families in Society: The Journal of Contemporary Human Services
#17 Childhood trauma, attachment style, and a couple's experience of terminal cancer: case study 67				
2010	McLean, Linda M. Hales, Sarah	PhD Clinical Psychologist M.D. F.R.C.P.(C)	Uni. Of Toronto, Ontario, Canada	Palliative and Supportive Care
#18 Psychic pain resurfacing in dementia (in Past Trauma in Late Life Ed. Hunt, L. et al) 60				
1997	Miesen, BèrèM.L. Jones, Gemma M.M.	Clinical Psycho-gerontologist Neuropsychologist	Psychogeriatric Centre, Leiden, Netherlands St Mary's Hosp., London, UK	Past Trauma in Late Life – Chapter 10
#19 Sibling relationships among older adults 68				
1992	Moyer, Martha S.	Social Worker – Private Practice & University	Long Beach, CA, USA	Generations

Master Table 1. The Master Table of Texts <i>(Included)</i>				
Year	Author/s	Profession/s	Situated	Journal/Book
#20 Physical and sexual abuse, battering and substance abuse: three clinical cases of older women 51				
2002	Osgood, Nancy J. Manetta, Ameda A.	Prof. Gerontology & Sociology Assis. Prof. Dept. Social Work	University, Richmond, VA, Winthrop Uni., Rock Hill, SA, USA	Journal of Gerontological Social Work
#21 Seventy years of mistrust: elderly survivors of sexual abuse 55				
2006	Resnick-Cortes, Cheryl	Prof. Social Work & Gerontology	Georgian Court Uni., New Jersey, USA	Reflections
#22 Geriatric dissociative identity disorder 58				
1997	Rosik, Christopher H.	PhD Psychologist	Christian Counseling Service, Fresno, CA, USA	Clinical Gerontologist
#23 Complex case from science to services: developing a neuroscience-based innovative clinical treatment model to manage severe and repetitive self-harm in a 60-year old woman with severe personality disorders 66				
2010	Sarkar, Jaydip	Forensic Psychiatrist	Centre Forensic Mental Health, Leicester, UK	Personality and Mental Health
#24 'Out of the silence' when people can't talk about it (in Past Trauma in Late Life Ed. Hunt, L. et al) 52				
1997	Sutton, Laura	Clinical Psychologist	Western Comm. Hospital, Southampton, UK	Past Trauma in Late Life – Chapter 11
#25 Adult survivors of childhood sexual abuse (in Art Psychotherapy 2 nd Edition Wadeson, H.) 69				
2010	Wadeson, Harriet	PhD Social Worker	Uni. Illinois, Chicago, Ill, USA	ART Psychotherapy 2 nd Edition, Ch. 8
#26 That was then: elderly survivors of incest 63				
1992	Walter, Kathleen	Psychiatric Clinical Nurse Specialist	D.V.A., Medical Centre, Pittsburgh, PA, USA	Journal of Psychosocial Nursing
<i>The number before the Title is its unique identifying number [#] used in related Tables</i>				

Relational Table 1.1 The Older Adult Survivors						
#	Case #	Age	Sex	Name	Country+	Current Situation
1	1	79	F	Not Given	USA, Black	Widowed 6 years, living independently in senior citizen housing facility.
	2	66	F	Not Given	USA, White	Married, living with husband.
	3	81	F	Not Given	USA, White	Widow, living independently in an older adult congregate housing facility.
2	1	79	F	Mrs. L	USA	Married 8 years, divorced, another 20 year relationship, recent death of child.
3	1	63	F	Not Given	African-American	Obese. Caring for her 89 yr old mother. No intimate relationships.
4	1	77	F	Not Given	UK	Widow. 2 nd husband died 2 months before, divorced violent 1 st husband
5	1	66	F	Mary	Swedish	Working woman, artistically gifted, in 2 nd marriage with adult son from 1 st . Both husbands alcoholic.
6	1	66	F	Not Given	UK	Diagnosed with Alzheimer's 3 years before.
7	1	90	F	Mrs. T	USA	Married in her 60's after caring for elderly adoptive parents. Widowed after 3 yrs. Recluse for 25 yrs. Living in assisted living facility. Now unable to walk.
8	1	61	F	Anna	USA	Retired from business career. Married to 3 rd husband for 10 yrs. No children by choice.
	2	60	F	Beth	Sister to 8.1	Married more than 30 years with 2 grown sons. Working in a clerical position.
9	1	69	F	Edna	USA	Husband very ill, father still alive at 93.
10	1	76	F	T.	USA	Older college student. Never married. Cared for mother. No siblings. Unstable childhood.
11	1	64	F	Not Given	USA, Caucasian	Living alone, never married. Born when mother in 40's, nearest sibling 15 yrs senior.
12	1	73	F	Not Given	USA	Married. Significant turmoil in family – son murdered, husband abusive.
13	1	60	F	Mary	USA, Caucasian	Married 41 yrs. Relocated after husband retired. Children, family and many friends no longer nearby.
	2	82	F	Anna		Widowed. Was a secretary, raised 3 children, husband died 8 yrs ago. Worsening health.
	3	75	M	Saul		Married. Abused alcohol until 61. Retired salesman. Worrier & perfectionist.
14	1	81	F	Myra	USA, German	Recently diagnosed with breast Ca, undergoing treatment.
	2	63	M	Jose	USA, Dominican	Married. Recently diagnosed with prostate Ca, treated with surgery.
15	1	67	M	Mr. X	UK	Never married, only companion a dog. Never had a confiding relationship. Retired foundry worker, army, scout leader. Abstinent 15 yrs. Psychotic illness.
16	1	76	F	Mrs. L	USA,	Married 60 yrs. Husband aware of abuse before marriage and taunts her. Above average intelligence.

Relational Table 1.1 The Older Adult Survivors						
#	Case #	Age	Sex	Name	Country+	Current Situation
	2	82	F	Mrs. M	Appalachian	Married sweetheart, widowed. Cares for severely handicapped 42 yr old daughter. Lived in same area all life. Needing surgery.
	3	68	F	Ms. B		Never married. Dog only companion. 2 younger sisters, occasional contact.
	4	83	F	Mrs. H		Widow lives alone since husband's death 20 yrs ago. 2 children nearby, frequent contact. Busy gardener but takes to bed occasionally.
17	1	60	F	Heather	Canada, Caucasian	Married, younger husband. Disability pension. Metastatic ovarian Ca 2 yrs. Died in hospital.
18	1	88+	F	Mrs De Bever	Netherlands Village	Widowed at 81 living with alcoholic, abusive son. Alzheimer's diagnosed at 85. Moved into a care home at 89.
19	1	60's	F	Maria	USA	Maria and Paulina siblings. Have a brother Jose who knew about the abuse
	2	60's	F	Paulina		
20	1	80	F	Veronica	USA	Never married, no children. Living in senior's high-rise. Disability. Was alcoholic, lived in squalor - Guardian controls finances.
	1	80	F	Mrs. M	USA	Divorced. 3 sons. Wheelchair bound. Admitted to assisted living residence. Angry, difficult. Incontinent but refusing help.
21	2	79	F	Mrs. S		Widow. Lives with g'daughter & family. 3 adopted daughters. Spouse angry & abusive.
	3	63	F	Ms. C		Never married. Talented, was a teacher, is an artist & poet. Has a sister.
22	1	63	F	Not Given	USA, Hispanic	Recent move near other family members. Dysfunctional family of origin- father to prison - attempted murder of mother.
23	1	60	F	Not Given	UK	Secure hospitals for 30 years. Dysfunctional life – prostitution, abusive relationships.
24	1	66	F	Joan	UK	Abusive husband died 5 yrs before. Ran away to daughter up north. Little known about history. 2 daughters 4 grandchildren and 1 son. Daughter also has issues.
25	1	60	M	Mike	USA	Married, 2 adult children, not happy, successful businessman, artistic.
26	1	Elderly	F	Not Given	USA	Lives alone in an apartment. Very lonely following a recent out of state visit to her children and grandchildren. Ruminating on abuse.
<p># - is the unique number assigned to each paper or text in Master Table 1</p> <p>Case # is the number assigned to each Older Adult Survivor in each Text [#.Case#] is a unique identifier</p> <p>Country+ - also includes any cultural information provided</p>						

Relational Table 1.2 The Abuse & Consequences					
#.Case#	Age	Perpetrator	Other ACEs*	Re-victimisation	Other
1.1	Until 14yrs	Grandfather	Grandmother physically abusive.	Not stated	Married at 14 to escape.
1.2	12yrs	2 uncles	Not stated	Not stated	Not stated
1.3	Not stated	Father	Not stated	Husband (alcohol) Recent attack by neighbour.	Not stated
2.1	From 6 for 6-7 yrs	Brother	Not stated	Not stated	Husband was Manic Depressive.
3.1	3yrs	Step-father	Not stated	Not stated	Mother did nothing.
4.1	Early life	Father	Not stated	1 st husband	Her sisters were also abused.
5.1	From at least 8yrs	Father	All the family terrified of him.	Father & both husbands; alcoholic.	Blames mother.
6.1	Not stated	Step-father	Also physically abusive.	Not stated	Mother made her follow step-father & report on affairs.
7.1	Until 9yrs	Adoptive father	Given up for adoption by divorced mother.	Not stated	Not stated
8.1	10 to 14yrs	Catholic priest	Threatened with going to "hell"	She feels; by the Catholic Church.	In presence of her sisters; also abused.
8.2	8 to 12yrs	Catholic priest	Threats – no one would believe her.	Not stated	In presence of her sisters; also abused.
9.1	Until 14yrs	Father	Not stated	Not stated	Married at 14 to a much older man she did not love.
10.1	Preteens	"Some boys"	Father; physical, emotional abuse & abandonment. Mother unstable.	During school – other students and teachers.	Father; alcoholic. Very dysfunctional early and later life.
11.1	From small child until 11 yrs ago	Brother	Father deserted family.	Not stated	Lives in fear siblings will find out.
12.1	Not stated	Father	Also physically abusive.	Recent abuse by husband.	Significant turmoil – son murdered.
13.1	Early adolescence At 8 yrs	Father + Older sister coerced her into mutual masturbation.	Physical & verbal abuse, by alcoholic parents.	Alcoholic husband of 41 yrs; sexually, physically, verbally abused.	Five siblings also physically abused.
13.2	9 to 11 yrs	Uncle	Not stated	Fearful of being attacked as becoming more frail.	Not stated

Relational Table 1.2 The Abuse & Consequences					
#.Case#	Age	Perpetrator	Other ACEs*	Re-victimisation	Other
13.3	9yrs +	Male strangers	Father distant & punitive.	Repeatedly beaten & sodomized in reform school.	Abused alcohol until 61. Sexually abused his younger sister when he was 13.
14.1	Not stated	Father	Not stated	Not stated	Triggered by simulation for radiotherapy.
14.2	Pre-school until 8yrs	Mother & Step-father	Mother would hold him down.	Not stated	Ca surgery was the trigger.
15.1	Not stated	Older boys in catholic orphanage.	Rejected at birth by prostitute mother.	Not stated	Also claims to have abused boys when a scout master.
16.1	11 to 16yrs	Father	Miserable teenage years	Husband aware & taunted her.	Contacted an STD from father.
16.2	Until puberty	Older brother	Violent sexual-abuse.	Not stated	He moved onto a younger sister
16.3	Young girl	Father & grandfather	Abuse so severe; made infertile.	Not stated	Mother did not help. Sisters also abused by grandfather.
16.4	Not stated	Father	Not stated	Not stated	Father a drunken hellcat.
17.1	Early history	Numerous males both intra- & extra-familial.	Maternal absence & neglect. Extensive physical & emotional abuse.	Marital distress – angry words.	Only child raised by single mother. 3 suicide attempts.
18.1	Until 18yrs	Father	At 11 cared for whole family. Pregnancy as result of incest.	Son, an alcoholic, is suspected of violence & sexual abuse of mother.	Married at 18 due to pregnancy – had 12 more children.
19.1	Teenage years	Father	Brother threatened with death if he told.	Not stated	Superficial relationships with siblings until death of father.
19.2	Teenage years	Father	As above	Not stated	As above
20.1	10 until 18yrs	Father's "buddy" - lived with him & his wife	Mother died when 8. Emotional abuse - nobody else would want her.	Not stated	Alcohol abuse, living in squalor, then prescription drug abuse.
21.1	Not stated	Father	Not stated	Institutionalised in old age: unable to protect body from invasion.	Felt mother did not protect her.
21.2	4yrs until forced to leave	Step-father	Disclosed to mother, ostracised & forced to leave.	Early marriage. Husband an angry, abusive man.	Made infertile. Sister also sexually abused.
21.3	Young child	Maternal grandfather	Not stated	Not stated	Little memory, mainly nightmares. Sister also possibly abused.

Relational Table 1.2 The Abuse & Consequences					
#.Case#	Age	Perpetrator	Other ACEs*	Re-victimisation	Other
22.1	Until 11yrs	Mother's boyfriends & Johns.	Prolonged very severe physical, emotional abuse & neglect.	Gang raped by brothers of a friend.	Extensive prescription drug use. Dissociative disorder with numerous surgeries.
23.1	4 to 5yrs	Father	Dysfunctional family, child blamed by mother for marriage breakup.	Statutory care at 12. Sex worker – often assaulted. Abusive relationships.	Neglected, abused & attempted to kill her child. Long Psychiatric history. Repetitive self harm, assaultive.
24.1	Not stated	Brother	Not stated	Enduring abuse by husband.	Challenging behaviour.
25.1	Not stated	Older brothers	Father alcoholic, absent, abusive. Depressed, inaccessible mother.	Not stated	Driven to succeed. Unhappy family life.
26.1	3 to 16	Guardian	Following the death of her parents.	Not stated	Not stated
<p>[#.Case#] is a unique identifier e.g. Paulina is 19.2</p> <p># - is the unique number assigned to each text in Master Table 1 and</p> <p>Case # is the number assigned to each Older Adult Survivor in each text in Relational Table 1.1</p> <p>*ACEs are Adverse Childhood Experiences e.g. physical & emotional abuse, death of a parent etc.</p>					

Relational Table 1.3 The Disclosure History		
#.Case #	Current Disclosure	Disclosure Over the Life Course
1.1	After 4 weeks of psychotherapy	Not stated
1.2	After 5 weeks of couple counselling	Not stated
1.3	After 5 counselling sessions + 3 additional months	Not stated
2.1	During initial detailed history taking	Revealed to psychiatrist she saw for several years; more interested in husband's mental health; did not question her about the incest
3.1	During a counselling session of a 6 week caregiver stress program	Revealed to a female psychiatrist she saw for several years; more interested in care-giving problems; never asked about incest.
4.1	Emerged during therapy	Not stated – regarded as highly confidential, did not want her GP or family to know
5.1	Recalled after a week of intensive psychodynamic therapy	1 year before prompted by advert. to wonder if distress due to childhood experiences. After recall –remembered being afraid father would kill her if she disclosed.
6.1	Not stated	Not stated. Had attended a psychiatric clinic eight years before with depression.
7.1	1.5 hours into wound care nurse home visit; during casual reminiscence	Avoided telling anyone, even during 'deep analysis'.
8.1	8.1 Anna, discussed with her 3 sisters when clerical abuse appeared in newspapers –	Threatened with going "to hell", afraid & couldn't tell anyone, never discussed with anyone.
8.2	they all decided to sue when Californian law changed to allow for prosecution for abuse decades before.	Confessed to another priest who told her to stop lying or she would "go to hell". Sisters did not even talk to each other; ashamed.
9.1	During life review in therapy began to deal with childhood sexual abuse for first time.	Not stated.
10.1	During counselling.	Not stated – had previous counselling
11.1	After 3 months of counselling; a big breakthrough in her ability to trust.	Never tried to run away or scream: "What for? No one would hear." Afraid family will find out.
12.1	Psychiatric consultation identified issues including childhood sexual abuse.	Not stated
13.1	During therapy.	Had purposely "forgotten" memory for many years. She once told her mother who did not believe her; no one else since.
13.2	During 3 rd therapy session.	Never disclosed to parents or anyone else.
13.3	After 6 months therapy slowly revealed his abuse of his sister and then his own childhood sexual abuse history.	Had offered himself sexually to his uncle & older brother when 11. Now ruminating & wanting to "atone" for his sins.

Relational Table 1.3 The Disclosure History		
#.Case #	Current Disclosure	Disclosure Over the Life Course
14.1	Triggered during Cancer treatment, then disclosed to Social Worker.	Not stated
14.2	Triggered after surgery for Cancer then disclosed to wife.	Not stated
15.1	Known - long psychiatric history.	Not stated
16.1	During life review therapy	History known to husband because of close family ties in isolated rural community.
16.2	During life review; recall using a 'prop', a childhood doll with arms ripped off.	Remembered very little about her childhood; no recall of life between 4 & 10 yrs old.
16.3	Took months for her to agree to life review therapy; but then readily admitted her rage at childhood sexual abuse.	Since young, her sister encouraged her to forget the abuse and "move on with her life". 2 younger sisters also abused & never told each other.
16.4	During life review therapy, openly related stories of father "doing things"; changed topic if probed.	Not stated
17.1	During psychosocial oncology therapy.	Not stated. Long history of depression and suicide attempts.
18.1	Known – although dementia brought to fore the old trauma of childhood sexual abuse.	Offered therapy in 1993 for severe anxiety & depression before dementia advanced.
19.1	Sought professional help because of memories of childhood sexual abuse for the 1 st time, after the death of her father.	Brother had known but threatened with death if he told or did anything. Each sibling had handled their part of the 'secret' by avoiding emotional closeness with each other.
19.2	Revealed to sister, above, when asked.	
20.1	Suicidal; therapy 1 year; case closed, again suicidal; re-opened immediately talked about childhood sexual abuse (1990's now, not kept a secret).	Never told anyone (did not want to go to grave without ever telling anyone what was done to her).
21.1	After several sessions with Social Worker revealed inability to accept help with personal care due to childhood sexual abuse.	When young unable to talk about abuse; felt it was somehow her fault.
21.2	Weeks of therapy; childhood sexual abuse 1 st relayed through nightmares. Over time revealed abuse at 4yrs of age.	When she finally revealed to her mother, she was ostracised & forced to leave home. Sister also abused & recently disclosed to each other.
21.3	During therapy for extreme anxiety; believes she was abused & thinks it was her grandfather.	Once when complaining about a recurring nightmare, her priest told her to touch the disgusting sight; corpse disappeared. Sister once asked her if ever abused, but no discussion.
22.1	After initial contact with psychiatrist, referred for psychological therapy; developmental history revealed prolonged & severe childhood abuse.	Once after severe sexual abuse taken to hospital; treated & released to mother to happen again soon after. For over 3 decades during adulthood, symptoms misdiagnosed by a variety of health care providers.

Relational Table 1.3 The Disclosure History		
#.Case #	Current Disclosure	Disclosure Over the Life Course
23.1	Known – long psychiatric history	As child mother disbelieved her and blamed her for break-up of marriage. Moved into statutory care.
24.1	2 years in dementia unit - Matron wondered if she had been abused as a child because of fear of men & touch. 1 yr later started to disclose abuse.	Not known
25.1	During art therapy.	Not stated
26.1	Patient in a geriatric psychiatric unit; frequently ruminated openly about her childhood incest.	Not stated
<p>[#.Case#] is a unique identifier e.g. Paulina is 19.2</p> <p># - is the unique number assigned to each text in Master Table 1 and</p> <p>Case # is the number assigned to each Older Adult Survivor in each text in Relational Table 1.1</p>		

Relational Table 1.4 The Presentations & Problems		
#.Case#	Presenting Symptoms or Problems	Underlying Problems
1.1	Self presented to psychotherapist – sleeping difficulties, poor appetite, disorientation, general fatigue, inability to maintain personal hygiene - more acute since husband's death 6 yrs before.	Chronic Depression Unhappy most of life.
1.2	Sought couple counselling because of her "manic-depression". Lithium for 2 yrs with only minor relief. GP suspected Alzheimer's – memory & co-ordination problems	Not Manic Depression, re-diagnosed as suffering from Posttraumatic Stress Disorder, lithium ceased. No dementia.
1.3	Referred to psychotherapist – disorientation and withdrawal following 'accident' in her home - bruises.	Actually an attack by male resident. Afraid she had provoked attack. Long history of abusive relationships, trust issues, low self-esteem
2.1	Unresolved grief following death of one of her children.	Feelings of self-loathing, guilt, and belief of being undeserving. Ambivalent feelings about intimacy.
3.1	6 week counselling and stress reduction program targeting caregivers.	Increasing difficulty now having to provide hands-on care to mother who 'did nothing' to stop abuse. Hated her body now, coped by overeating.
4.1	Referred with low mood, constant crying, loss of appetite, social withdrawal & suicidal ideation 2 months after 2 nd husband's death.	Depression. Blamed early sexual abuse by father for death of her child, abusive 1 st marriage and inability to have sexual relationship with dearly loved 2 nd husband.
5.1	Self presented for Psychotherapy – for some time, severe distress that she could not relate to anything now or past.	Few childhood memories. Problem with men always "terrible threat", no sexual enjoyment. Husband alcohol problems.
6.1	Believed husband having numerous affairs, questioned him continually. Delusional jealousy -Alzheimer's diagnosis 3 yrs before.	Premorbidly sensitive and shy. 8 yrs before treated for depression secondary to an anxious personality and marital disharmony.
7.1	Referred for slow healing venous ulcers. Recluse for 25 yrs.	Looked after adoptive parents including abuser until their death, married in her 60's for 3 yrs. Estranged from people she had helped, depression during the menopause. Never disclosed.
8.1	Self presented for legal reasons – well presented lady.	Major Depressive Disorder, PTSD – Chronic Acute anxiety, mental confusion & depressed/ suicidal ideation, Interpersonal relationships limited or completely avoided
8.2	Self presented for legal reasons – Presented well.	PTSD – Chronic, Dysthmic Disorder. Most significant symptom – worthless, dissociative symptoms, mild suicidal ideation, social isolation.
9.1	Referred for therapy after becoming suicidal when husband became ill	Appeared her husband would die before her 93 yr old father who abused her. She had married at 14 to escape, a widower who was much older whom she didn't love. Paid with lifelong depression.
10.1	Intimidating behaviour in a community college – unreasonable demands for immediate service, staff stressed.	Dysfunctional life. Protected herself by controlling the environment & attacking before attacked. Unable to nourish herself she used others – this supported her Victim consciousness & toxic games.

Relational Table 1.4 The Presentations & Problems

#.Case#	Presenting Symptoms or Problems	Underlying Problems
11.1	"Talks" (as she called them) with a counsellor in a day care centre – isolation & inability to form close social ties.	Isolation, depression, low self-esteem – guilt, anger and aloneness. Extremely intelligent, but no sense of achievement. Difficulty trusting. Abuse by brother lasted into adulthood. Suicidal ideation.
12.1	4 yr history of intractable nocturnal seizures – diagnosed as psychogenic, conversion disorder.	Significant turmoil in family. Depression. Physical & sexual abuse in childhood and recent physical abuse by husband.
13.1	Self-presented to psychotherapist – depressed mood, irritability, hopelessness, anhedonia, suicidal ideation, insomnia, fatigue, feeling worthless, psychomotor agitation, anxious rumination.	Unhappy most of life. Severe depression 23 yrs earlier after son's death. Exacerbation depressive symptoms 2 yrs before after retirement of husband & relocation. Antidepressants unsuccessful. Abusive marriage, now with him day & night. Chronic depression & re-victimisation.
13.2	Psychotherapy at daughter's insistence. Severely restricted activities, fears of being attacked. She blamed worsening health.	Fearful & anxious of men as a child but overcame it – re-emerged in old age – stressors of physical limitations elicited same fears.
13.3	Recently increased anxious rumination, agitation, irritability, and insomnia. Antidepressant for several years without much symptom relief.	Abused alcohol much of adult life until 61. Retired. Worsening symptoms last 5 yrs. Had sexually abused his sister, now dead. Guilt & shame about abuse history, blamed self.
14.1	Breast Cancer – stormed out of her simulation for radiotherapy.	Darkness required for simulation, being partially disrobed, & technician "too much to bear" – reminded her of abuse. Had been struggling with suicidal thoughts since diagnosis.
14.2	Prostate cancer – became distressed and inconsolable as he recovered from anaesthesia.	Sexually abused by mother and step father – mother would hold him down.
15.1	Admitted to an acute psychiatric hospital because he had been saying odd things about abusing children and his dog.	Psychotic depression with delusions of guilt. Long psychiatric history. Normally withdrawn & lonely. Used to abuse alcohol.
16.1	Presented with depression combined with anxiety & mild dissociation.	When husband around disorientated & confused. Perfectly lucid when alone. Because of close family ties, husband knew of abuse & taunted her.
16.2	Referred for mental health counselling - felt depression contributing to refusal to allow anyone to care for disabled daughter.	Afraid someone might take sexual advantage of her daughter. Terror so real she refused own care. Based on her own traumatic experiences as a child.
16.3	Referred for counselling - beginning to engage in self-mutilating behaviours, frequent accidents, & suicidal ideation.	Blamed father for loneliness caused by lack of a husband & children (infertile by abuse). A lifetime of rage had left her bitter, depressed and agitated.
16.4	Referred for mental health counselling for frequent depressive episodes during which she confined herself to bed.	Lived alone since husband's death 20 yrs before. Usually well orientated & generally happy. Depressive feelings passed in a day or two.
17.1	Referred to psychosocial oncology for assistance coping with advancing disease and end of life.	Disease amplifying longstanding relational distress. Long history depression unresponsive to AntiDs. Chronic suicidal ideation. Possible cPTSD.

Relational Table 1.4 The Presentations & Problems		
#.Case#	Presenting Symptoms or Problems	Underlying Problems
18.1	History of Alzheimer's. Offered therapy for her severe anxiety & depressive periods.	Over time, past experiences more intrusive & distressing, surfacing when her grasp of what was happening around her was becoming less secure.
19.1	After death of father, memories, 1 st time, being sexually assaulted by him. Unable to handle memories, sought help.	Encouraged to ask siblings, startled to learn that sister also abused and that brother had known. All had avoided emotional closeness with each other.
19.2	Sister of above – similar fate	As above
20.1	Referral from primary physician – had recently threatened to kill herself.	History of alcohol, then prescription drug abuse. Had lived in squalor, now under guardianship. Never married or had children. Thought the abuse was because she was deformed.
21.1	Angry outbursts & inability to cooperate with staff in residential care. Incontinent & refused to let staff bathe & clean her.	Inability to accept personal care because of childhood sexual abuse. Unable to maintain her own personal hygiene, poor mobility.
21.2	Major depressive disorder	Depressed as far back as she could remember. Husband angry, abusive man. Severely damaged self-esteem. Developing trust difficult. Nightmares.
21.3	Low self-esteem & episodes of extreme anxiety.	Never married. Artistic. Nightmares.
22.1	Referred for ongoing psychological treatment of a suspected dissociative disorder.	Blackouts since 1970's. Extensive history of prescription drug use. Chronic history of anxiety & depression. At least 11 surgeries for a variety of conditions. Severe childhood abuse.
23.1	Repetitive self-harm in a women who has been in secure hospitals for the last 30 yrs. Trial of a model to manage her behaviour.	Severe childhood sexual abuse. Dysfunctional life history. Dg - Acute & transient psychotic disorder, depressive disorders, dissociative & conversion disorders plus various personality disorders
24.1	'Complex' behaviours in a residential dementia unit (does not have dementia)	Previous depressive illness, serious suicide attempt & ECT. Now afraid & childlike, unable to control her feelings & thus her behaviour. 3 states.
25.1	Sought therapy because had just turned 60 and was depressed feeling he had wasted his life.	Father alcoholic, mother inaccessible. Grew up in poor neighbourhood, now a successful businessman. Quarrelled frequently with wife. Distrustful.
26.1	Admitted to the geriatric psychiatric unit with prominent anxiety symptoms, panic attacks, depressed mood, anhedonia, and dependent personality traits.	Frequently ruminated about past abuse. Precipitated by recent return from visiting family. Overwhelming feelings of loneliness.
<p>[#.Case#] is a unique identifier e.g. Paulina is 19.2</p> <p># - is the unique number assigned to each text in Master Table 1 and</p> <p>Case # is the number assigned to each Older Adult Survivor in each text in Relational Table 1.1</p>		

Relational Table 1.5 The Treatments & Therapies		
#.Case#	Rx Time	Treatments (Rx)
1.1	11 months	Self presented to male psychotherapist; counselling consisted of music & art therapy, bibliography, in-depth discussions about the impact of unresolved childhood sexual abuse on self-concept.
1.2	4 months 7 months	Couple counselling – after disclosure referred to: Adult survivor support group & female therapist for individual counselling Re-evaluated by a psychiatrist familiar with childhood abuse issues – lithium stopped, re-diagnosed with Posttraumatic stress disorder.
1.3	3+ months	Referred to male psychotherapist – after disclosure for: Individual counselling, art therapy & assertiveness training.
2.1	Not stated	Psychotherapy by a Social Worker
3.1	6 weeks	Social Work counselling & stress reduction program for caregivers
4.1	Not stated	Offered individual systemic therapy (derived from family therapy) to talk about family relationships – major issues; quality of intimate relationships, grief, forgiveness, recovery & protection. General Practitioner prescribed anti-depressants.
5.1	2 years	Self-presented for psychotherapy – intensive psychodynamic therapy. Expressed experiences creatively with drawings, paintings & patchwork. Husband started therapy for problem drinking.
6.1	Not stated	Referred to a psychogeriatric service. Treated with antipsychotics which reduced intensity of jealousy but the problem persisted.
7.1	Ongoing	An ongoing relationship with the Clinical Nurse Specialist is important – may offer healing techniques like therapeutic touch, or facilitate appropriate referral or if refuses create an accepting, non-judgemental environment of privacy and safety.
8.1 8.2	Not treated here at this time	Initially will need an empathetic, real relationship with an experienced therapist. Ultimately, intensive therapeutic intervention (basis psychoanalytic – transference major focus); anti-anxiety & antidepressant medication considered in conjunction with the dynamic treatment. Choice of optimal approach difficult in absence of systematic treatment outcome data for such complex cases.
9.1	Not stated	Life Review in therapy. A sexual history is an important part of life review and should not be left out for older women
10.1	Several years	Counselling in a Community College. “When working with toxic clients, traditional counselling or psychotherapy is counterproductive. ...Find the co-Victim. ... teach him or her the coping and change strategies...”
11.1	3 months +	Counselling in a Day Care Centre.
12.1	5 nights	Anti-epileptic drugs ceased with no worsening of seizures. Obtained diagnosis of conversion disorder. Prescribed anti-depressants. Referred to a psychiatrist.
13.1	Over 2 years	Self presented to female psychotherapist. Had tried antidepressants unsuccessfully. First addressed safety & coping skills, then attention to abuse history. Cognitive approaches to improve self-esteem. Assertiveness training when anger emerged. Self-protective strategies & Safety Plans developed when considering divorce.

Relational Table 1.5 The Treatments & Therapies		
#.Case#	Rx Time	Treatments (Rx)
13.2	4 sessions	Psychotherapy at daughter's insistence. Terminated after 4 sessions. Perhaps graduated exposure assignments may have been used to decrease anxiety & test the validity of her fears.
13.3	More than 3 years	Anti-depressant for years without much symptom relief. Cognitive-behavioural strategies initially to reduce obsessional thinking; little progress made. Significant transference with 1 st therapist, a young female who reminded him of deceased younger sister who he had abused. Worked with 3 therapists. 2 females and 1 male. Educated about effects of CSA e.g. hypersexuality. Faulty beliefs about blame addressed. Focal point became abuse of his sister.
14.1	During Cancer treatment	Demonstrated suicidal and/or self injuring behaviour. Psychiatric intervention took precedence; agreed to a brief voluntary psychiatric hospitalisation & was then maintained on medication throughout Cancer treatment.
14.2	During Cancer treatment	Containment interventions used during severe distress. Recommended that traumatic memories not be explored until recovery from surgery & then in gradual, measured way in a mental health setting.
15.1	Ongoing	Admitted to acute psychiatric hospital – after 2 days detained under Mental Health Act. Special "at risk" multiagency meeting, with his agreement – ongoing treatment & careful follow up in a clinic & in the community by a nurse. Ongoing counselling by a senior psychologist.
16.1	Adapted Life Review – referred by public health nurse to female therapist (private) – in their homes for 6 to 8 months.	Visited father's grave. With older women must exercise caution by balancing confrontation of dysfunctional coping mechanisms with preservation of those mechanisms that maintain emotional integration.
16.2		Use of "props" here a childhood doll with no arms [later recalled ripping them off in anger at brother's abuse]. Aid to memory recall & an important outlet for nonverbal expression [she sewed arms back on].
16.3		Need to confront family members –may need to be symbolic by direct verbalisation [recorded the imaginary conversations she had wanted to have for 50 years] & visits to graves. Second phase involved sessions with siblings.
16.4		Empowerment. Respect the conscious choice not to revisit the abuse. Decided not to participate in Life Review.
17.1	From diagnosis metastatic Cancer to death ~ 2 years	Palliative Care physician – desire for hastened death. Referred to psychosocial oncology for assistance coping with disease and end of life. Psychologist for marital therapy using modified Emotionally Focused Therapy. Inpatient palliative care after suicide attempt. Psychiatric consultation – she dismissed pharmacotherapy. Pain & symptom relief. Delirium. Containment measures. Sedating medication. Death. Husband followed up by psychologist in bereavement.
18.1	5+ years	Interventions must fit stage of dementia & same techniques can be used for different goals e.g. reminiscence work. Eventually required psychogeriatric residential care. Had therapy for severe anxiety & depression, due to cognitive deterioration, therapeutic goal became palliative, concentrating on social & emotional support – safety, optimal sensory & mental stimulation & a predictable routine – all providing psychological comfort.
19.1	Not stated	Utilising the sibling support system. Therapist advised her to ask her siblings for confirmation of memories. Allowed siblings to support & eventually get to know each other as they worked on their individual & family healing.
19.2	Not stated	

Relational Table 1.5 The Treatments & Therapies		
#.Case#	Rx Time	Treatments (Rx)
20.1	1 year +	Referral to female Social Work therapist by primary physician. First Safety Plan, then Education about childhood sexual abuse, taught self-care, therapeutic intervention based on Reminiscence Therapy [vehicle the Oprah Show], ongoing evaluation, termination, follow-up. Pacing important.
21.1	Many months	Female gerontological social worker called to evaluate behavioural problems in a residential aged care facility. Difficulty writing so encouraged to compose mental letters to her long deceased father, vocalising feelings about abuse. Helped to differentiate the current experiences from the past.
21.2	3 years	Female gerontological social worker. Strength based – incorporating faith, the spiritual & the religious. Enormous difficulty establishing trust.
21.3	Ongoing	Working on issues of decreasing anxiety as well as increasing good feelings about herself & her capabilities.
22.1	Ongoing	Male psychologist. Ongoing psychological treatment of a suspected dissociative disorder. Confirmation was obtained with little effort in therapy. Due to monetary constraints could only be seen on bi-weekly to monthly basis, necessitating a more supportive approach to treatment. Remains in supportive psychotherapeutic modality with adjunctive monitoring by her psychiatrist.
23.1	Ongoing	Forensic psychiatric hospital. Innovative model based on neurobiology of threat management- promotes social engagement & affect regulation as a strategy to manage heightened threat perceptions & aggression to self & others. Unified framework rather than driven by multiple, disparate factors.
24.1	2 years +	Referred to a female clinical psychologist for behavioural problems in a residential aged care facility. Cognitive- analytic therapy (4 assessment sessions, then 12 intervention sessions). Containment techniques for staff. Boundary setting. Understanding behaviour rather than diagnosing pathology. Palliative intervention (quality of life) rather than cure.
25.1	1 year	Art psychotherapy (female therapist). Psychoanalytically based. Also referred for massage before art therapy sessions to deal with shame about his body.
26.1	Inpatient + Follow Up	Admitted to a geriatric psychiatric unit. Treatment consisted of a holistic approach that incorporated psychotherapy, milieu therapy, & an antidepressant medication. Discharged with psychiatric follow up, referral to a local senior centre & the opportunity to work as a volunteer.
<p>[#.Case#] is a unique identifier e.g. Paulina is 19.2</p> <p># - is the unique number assigned to each text in Master Table 1 and</p> <p>Case # is the number assigned to each Older Adult Survivor in each text in Relational Table 1.1</p>		

Relational Table 1.6 The Outcomes of Interventions	
#.Case#	Outcomes of Interventions
1.1	More energy, better appetite & sleeping & physical care, more satisfying relationships.
1.2	Re-diagnosed, happier, improved memory, more interest in social interaction.
1.3	No confusion, can live independently, less depressed, more time interacting.
2.1	Not stated
3.1	Not stated
4.1	Not stated except given the opportunity to share her experiences and reflect on them.
5.1	Happier, more creative, closer relationship with husband who is being treated for alcoholism
6.1	Antipsychotic medication reduced intensity of her jealousy but the problem persisted.
7.1	Improvement in leg ulcer, reduction in leg swelling, felt she had been really helped.
8.1	No treatment at this time
8.2	No treatment at this time
9.1	Not stated but began to deal with sexual abuse from her childhood for the first time.
10.1	Boundaries established that improved coping for those she negatively affected.
11.1	Gave up suicide “stash”. Came a long way, not come to terms- guilt, anger & loneliness.
12.1	Stopped anti-epileptic medication, referred to a psychiatrist but did not attend
13.1	Less dysphoric & angry, better self-view, decreased verbal abuse from spouse.
13.2	Terminated therapy prematurely after 4 th session.
13.3	Believed he had made considerable progress towards resolving CSA & related existential issues. Less anxious, sleeping better, ruminating less.
14.1	Agreed to a brief voluntary psychiatric hospitalization & was well maintained on medication throughout the rest of her cancer treatment.
14.2	Made a conscious choice to focus on recovery from cancer before exploration of CSA.
15.1	Months on, depression seems a little better. Still lives a lonely life but dog returned to him. Given ongoing counselling and follow up to minimise risk to community.
16.1	Symptom relief but final resolution involved denial.
16.2	Consented to another daughter caring for disabled daughter & had successful surgery.
16.3	Verbalised forgiveness & grief. Shared issues with sisters – also abused.

Relational Table 1.6 The Outcomes of Interventions	
#.Case#	Outcomes of Interventions
16.4	Refused further therapy – her choice, stated the feelings passed in a day or two.
17.1	Better symptom control, marital bond strengthened – more support, empathy & love. A “good enough” death. Treating team not demoralized.
18.1	More frequent periods when seems overtly happy & able to join in communal activity.
19.1	Opening up of the family secret allowed the siblings to support & finally to get to know each other as they worked on their individual & family healing.
19.2	
20.1	Had been suicidal, now at 80 had been able to disclose for the first time.
21.1	Able to vent anger. Opened up to warmth & able to receive care.
21.2	Not stated. Worked with her for 3 years.
21.3	Working on decreasing anxiety & increasing good feelings about herself & capabilities.
22.1	Reduction in duration & frequency of blackouts, relatively high level of functioning.
23.1	Reduced self harm, increased trust – anxieties reduced, can leave hospital grounds.
24.1	Maintained gains. Travelled by herself on a train to visit daughter. More sociable & sought help. Died in sleep. Supervision also helped staff.
25.1	Art therapy ended after a year. Moved to Florida, marriage happier, building a workshop, going fishing & volunteering at a youth centre.
26.1	Symptoms improved over 8 weeks therapy. Increased energy & an interest in helping others, works as a volunteer in local senior centre. More involvement in church.
<p>[#.Case#] is a unique identifier e.g. Paulina is 19.2</p> <p># - is the unique number assigned to each text in Master Table 1 and</p> <p>Case # is the number assigned to each Older Adult Survivor in each text in Relational Table 1.1</p>	

Appendix II - Search Strategy

Logic Matrices containing final Boolean searches

The detailed database searches appear below. All searches only included the two main concepts, adapted for each database, that is:

1: Childhood Sexual Abuse and 2: Older Adults.

Text and Opinion was not introduced as a separate concept because preliminary test searches found it to be not useful, and to reduce the number of retrievals dramatically.

Logic Matrix Search Strategy 1 - Scopus	
Database	Scopus
<p>Concept 1: Childhood Sexual Abuse</p> <p>MeSH {child abuse, sexual} OR incest OR pedophilia OR {adult survivors of child abuse}</p> <p>EMTREE {child sexual abuse} OR (((child abuse} OR {battered child syndrome}) AND {sexual abuse}) OR incest</p> <p>KEYWORDS {child sexual abuse} OR {childhood sexual abuse} OR {child sexual assault} OR {childhood sexual assault} OR {child sexual molestation} OR incest* OR molestation OR {child abuse survivor} OR {adult survivors of child abuse} OR {adult survivors of sexual abuse} OR {adult survivors of sexual assault} OR Pedophil* OR Paedophil* OR Pederast*</p> <p>Combined: {child abuse, sexual} OR incest OR {adult survivors of child abuse} OR {child sexual abuse} OR (((child abuse} OR {battered child syndrome}) AND {sexual abuse}) OR {childhood sexual abuse} OR {child sexual assault} OR {childhood sexual assault} OR {child sexual molestation} OR incest* OR molestation OR {child abuse survivor} OR {adult survivors of sexual abuse} OR {adult survivors of sexual assault} OR Pedophil* OR Paedophil* OR Pederast*</p>	
<p>Concept 2: Older Adults</p> <p>MeSH aged OR {health services for the aged} OR {homes for the aged} OR {nursing homes} OR {housing for the elderly} OR {geriatric assessment} OR {geriatric nursing} OR {geriatric psychiatry} OR dementia</p> <p>[Comment: {aged} enter with Keyword search only]</p> <p>EMTREE aged OR {very elderly} OR aging OR {frail elderly} OR {elderly care} OR {aging care} OR senescence OR {nursing home care} OR {nursing home} OR {home for the aged} OR geriatrics OR {geriatric patient} OR {geriatric assessment} OR gerontopsychiatry OR dementia OR {Alzheimer disease} OR {multiinfarct dementia} OR {diffuse Lewy Body disease}</p> <p>Keywords {aged 65 and over} OR {aged 80 and over} OR {old age} OR {oldest old} OR {very old} OR {older women} OR {older men} OR {older adults} OR {older aged} OR {older patients} OR elderly OR {late life} OR {later life} OR {life review} OR {attitudes toward aging} OR ag?ism OR {elder care} OR {life review} OR {aging in place} OR {long term care} OR {retirement communities} OR {old age homes} OR {nursing homes} OR {residential aged care facilities} OR {care homes} OR {skilled nursing facilities} OR {aging in place} OR {geriatric patients} OR {geriatric psychotherapy} OR {old age psychiatry} OR {old age psychiatrist} OR geriatric OR geriatrician OR gerontolog* OR geropsycholog* OR psychogeriatric* OR Alzheimer's OR Alzheimer? OR {Corticobasal Degeneration} OR Pseudodementia</p>	

Logic Matrix Search Strategy 1 - Scopus	
Database	Scopus
<p>Combined (aged not included because not specific unless a MeSH or Emtree term)</p> <p>{health services for the aged} OR {homes for the aged} OR {nursing homes} OR {housing for the elderly} OR {geriatric assessment} OR {geriatric nursing} OR {geriatric psychiatry} OR dementia OR {very elderly} OR aging OR {frail elderly} OR {elderly care} OR senescence OR {nursing home care} OR {nursing home} OR {home for the aged} OR geriatrics OR {geriatric patient} OR {geriatric assessment} OR gerontopsychiatry OR {Alzheimer disease} OR {multiinfarct dementia} OR {diffuse Lewy Body disease} OR {aged 65 and over} OR {aged 80 and over} OR {old age} OR {oldest old} OR {very old} OR {older women} OR {older men} OR {older adults} OR {older aged} OR {older patients} OR elderly OR {late life} OR {later life} OR {life review} OR {attitudes toward aging} OR ag?ism OR {elder care} OR {life review} OR {aging in place} OR {long term care} OR {retirement communities} OR {old age homes} OR {nursing homes} OR {residential aged care facilities} OR {care homes} OR {skilled nursing facilities} OR {aging in place} OR {geriatric patients} OR {geriatric psychotherapy} OR {old age psychiatry} OR {old age psychiatrist} OR geriatric OR geriatrician OR gerontolog* OR geropsycholog* OR psychogeriatric* OR Alzheimer's OR Alzheimer? OR {Corticobasal Degeneration} OR Pseudodementia</p>	
<p>S7 Combining Concept 1: Childhood Sexual Abuse AND Concept 2: Older Adults</p> <p>(TITLE-ABS-KEY({child abuse, sexual} OR incest OR {adult survivors of child abuse} OR {child sexual abuse} OR ({child abuse} OR {battered child syndrome}) AND {sexual abuse}) OR {childhood sexual abuse} OR {child sexual assault} OR {childhood sexual assault} OR {child sexual molestation} OR incest* OR molestation OR {child abuse survivor} OR {adult survivors of sexual abuse} OR {adult survivors of sexual assault} OR pedophil* OR paedophil* OR pederast*) AND (TITLE-ABS-KEY({health services for the aged} OR {homes for the aged} OR {nursing homes} OR {housing for the elderly} OR {geriatric assessment} OR {geriatric nursing} OR {geriatric psychiatry} OR dementia OR {very elderly} OR aging OR {frail elderly} OR {elderly care} OR senescence OR {nursing home care} OR {nursing home} OR {home for the aged} OR geriatrics OR {geriatric patient} OR {geriatric assessment} OR gerontopsychiatry OR {Alzheimer disease} OR {multiinfarct dementia} OR {diffuse Lewy Body disease} OR {aged 65 and over} OR {aged 80 and over} OR {old age} OR {oldest old} OR {very old} OR {older women} OR {older men} OR {older adults} OR {older aged} OR {older patients} OR elderly OR {late life} OR {later life} OR {life review} OR {attitudes toward aging} OR ag?ism OR {elder care} OR {life review} OR {aging in place} OR {long term care} OR {retirement communities} OR {old age homes} OR {nursing homes} OR {residential aged care facilities} OR {care homes} OR {skilled nursing facilities} OR {aging in place} OR {geriatric patients} OR {geriatric psychotherapy} OR {old age psychiatry} OR {old age psychiatrist} OR geriatric OR geriatrician OR gerontolog* OR geropsycholog* OR psychogeriatric* OR alzheimer's OR alzheimer? OR {Corticobasal Degeneration} OR pseudodementia)) AND (EXCLUDE(PUBYEAR, 2012) OR EXCLUDE(PUBYEAR, 2011))</p>	

Logic Matrix Search Strategy 2- PubMed Medline	
Database	PubMed Medline
<p>Concept 1: Childhood Sexual Abuse</p> <p>#1 child abuse, sexual[MeSH Terms] OR incest[MeSH Terms] OR pedophilia[MeSH Terms] OR adult survivors of child abuse[MeSH Terms]</p> <p>#2 "child sexual abuse"[tiab] OR "childhood sexual abuse"[tiab] OR "child sexual assault"[tiab] OR "childhood sexual assault"[tiab] OR "child sexual molestation"[tiab] OR incest*[tiab] OR Pedophil*[tiab] OR Paedophil*[tiab] OR Pederast*[tiab]</p> <p>#5 with Age Limits <i>(can be used instead of using Concept 2 – results almost the same)</i></p> <p>(#1 OR #2) AND ("humans"[MeSH Terms] AND ("aged"[MeSH Terms] OR "aged, 80 and over"[MeSH Terms]) AND ("1"[PDAT] : "2010/12/31"[PDAT]))</p> <p>Concept 2: Older Adults</p> <p>#3 "aged"[MeSH Terms] OR "health services for the aged"[MeSH Terms] OR "homes for the aged"[MeSH Terms] OR "nursing homes"[MeSH Terms] OR "housing for the elderly"[MeSH Terms] OR "geriatric assessment"[MeSH Terms] OR "geriatric nursing"[MeSH Terms] OR "geriatric psychiatry"[MeSH Terms] OR "dementia"[MeSH Terms]</p> <p>#4 "Aged 65 and over"[tiab] OR "Aged 80 and over"[tiab] OR "Old age"[tiab] OR "Oldest old"[tiab] OR "Very old" [tiab] OR "Older women"[tiab] OR "Older men"[tiab] OR "Older adults"[tiab] OR "Older aged"[tiab] OR "Very old"[tiab] OR "Oldest old"[tiab] OR Elderly[tiab] OR "Frail elderly"[tiab] OR "Late life"[tiab] OR "Later life"[tiab] OR "Life review"[tiab] OR Senior\$[tiab] OR Elder\$[tiab] OR "Homes for the aged"[tiab] OR "Housing for the elderly"[tiab] OR "Old age homes"[tiab] OR "Nursing homes"[tiab] OR "Residential aged care facilities"[tiab] OR "Care homes"[tiab] OR "Skilled nursing facilities"[tiab] OR "Aging in place"[tiab] OR "Old age psychiatry"[tiab] OR "Old age psychiatrist"[tiab] OR Geriatric[tiab] OR "Geriatric nursing"[tiab] OR Geriatrician[tiab] OR Gerontolog*[tiab] OR Geropsycholog*[tiab] OR Psychogeriatric[tiab] OR Psychogeriatrician[tiab] OR Dementia[tiab] OR Alzheimer's[tiab] OR Alzheimers[tiab] OR "Corticobasal Degeneration"[tiab] OR Pseudodementia[tiab]</p> <p>#6 Limits – Human before 2011</p> <p>(#3 OR #4) AND ("humans"[MeSH Terms] AND ("1"[PDAT] : "2010/12/31"[PDAT]))</p>	
<p>#7 Combining Concept 1: Childhood Sexual Abuse AND Concept 2: Older Adults with limits Human and before 2011</p> <p>((#1 OR #2) AND (#3 OR #4)) AND ("humans"[MeSH Terms] AND ("1"[PDAT] : "2010/12/31"[PDAT]))</p>	

Logic Matrix Search Strategy 3 - CINAHL	
Database	CINAHL/CINAHL with Full Text
<p>Concept 1: Childhood Sexual Abuse</p> <p>S1 MH ("Child Abuse, Sexual" OR "Child Abuse Survivors" OR "Incest")</p> <p>S2 TI ("child sexual abuse" OR "childhood sexual abuse" OR "child sexual assault" OR "childhood sexual assault" OR "child sexual molestation" OR "incest" OR "incestuous" OR "molestation" OR "adult survivors of sexual abuse" OR "adult survivors of sexual assault" OR "child abuse survivors" OR Pedophil* OR Paedophil* OR Pederast*) or AB("child sexual abuse" OR "childhood sexual abuse" OR "child sexual assault" OR "childhood sexual assault" OR "child sexual molestation" OR "incest" OR "incestuous" OR "molestation" OR "adult survivors of sexual abuse" OR "adult survivors of sexual assault" OR "child abuse survivors" OR Pedophil* OR Paedophil* OR Pederast*)</p> <p>S5 S1 OR S2 with LIMITS (Published before 2011, Human and Aged 65+)</p>	
<p>Concept 2: Older Adults</p> <p>S3 MH ("Aged+" OR "Aging" OR "Ageism" OR "Gerontologic Care" OR "Long Term Care" OR "Residential Care+" OR "Aged, 80 and Over" OR "Dental Care for Aged" OR "Health Services for the Aged" OR "Geropsychiatric Nursing" OR "Housing for the Elderly" OR "Nursing Homes" OR "Geriatrics" OR "Geriatric Psychiatry" OR "Geriatric Functional Assessment" OR "Dental Care for Aged" OR "Gerontologic Care" OR "Gerontologic Nursing" OR "Geriatric Psychiatry" OR "Geropsychiatric Nursing" OR "Dementia+")</p> <p>S4 TI("Aged 65 and over" OR "Aged(65 yrs & older)" OR "Aged 80 and over" OR "Very old(85 yrs & older)" OR "Old age" OR "Oldest old" OR "Very old" OR "Older women" OR "Older men" OR "Older adults" OR "Older aged" OR "Very old" OR "Oldest old" OR Elderly OR "Frail elderly" OR "Late life" OR "Later life" OR "Life review" OR Senior\$ OR Elder\$ OR "Homes for the aged" OR "Housing for the elderly" OR "Old age homes" OR "Nursing homes" OR "Residential aged care facilities" OR "Care homes" OR "Skilled nursing facilities" OR "Aging in place" OR "Old age psychiatry" OR "Old age psychiatrist" OR Geriatric OR "Geriatric nursing" OR Geriatrician OR Gerontolog* OR Geropsycholog* OR Psychogeriatric OR Psychogeriatrician OR Dementia OR Alzheimer's OR Alzheimers OR "Corticobasal Degeneration" OR Pseudodementia) OR AB("Aged 65 and over" OR "Aged(65 yrs & older)" OR "Aged 80 and over" OR "Very old(85 yrs & older)" OR "Old age" OR "Oldest old" OR "Very old" OR "Older women" OR "Older men" OR "Older adults" OR "Older aged" OR "Very old" OR "Oldest old" OR Elderly OR "Frail elderly" OR "Late life" OR "Later life" OR "Life review" OR Senior\$ OR Elder\$ OR "Homes for the aged" OR "Housing for the elderly" OR "Old age homes" OR "Nursing homes" OR "Residential aged care facilities" OR "Care homes" OR "Skilled nursing facilities" OR "Aging in place" OR "Old age psychiatry" OR "Old age psychiatrist" OR Geriatric OR "Geriatric nursing" OR Geriatrician OR Gerontolog* OR Geropsycholog* OR Psychogeriatric OR Psychogeriatrician OR Dementia OR Alzheimer's OR Alzheimers OR "Corticobasal Degeneration" OR Pseudodementia)</p> <p>S6 S3 OR S4 with LIMITS (Published before 2011, Human)</p>	
<p>S7 Combine Concept 1: Childhood Sexual Abuse AND Concept 2: Older Adults (S1 OR S2) AND (S3 OR S4) with LIMITS (Published before 2011, Human)</p>	

Logic Matrix Search Strategy 4 - PsycINFO	
Database	PsycINFO & PsycARTICLES
<p>Concept 1: Childhood Sexual Abuse</p> <p>S1 DE(((("Child Abuse" OR "Battered Child Syndrome" OR "Child Abuse Reporting") AND "Sexual Abuse") OR "Incest" OR "Pedophilia")</p> <p>S2 TI ("child sexual abuse" OR "childhood sexual abuse" OR "child sexual assault" OR "childhood sexual assault" OR "child sexual molestation" OR "incest" OR "incestuous" OR "molestation" OR "adult survivors of sexual abuse" OR "adult survivors of sexual assault" OR "child abuse survivors" OR Pedophil* OR Paedophil* OR Pederast*) or AB("child sexual abuse" OR "childhood sexual abuse" OR "child sexual assault" OR "childhood sexual assault" OR "child sexual molestation" OR "incest" OR "incestuous" OR "molestation" OR "adult survivors of sexual abuse" OR "adult survivors of sexual assault" OR "child abuse survivors" OR Pedophil* OR Paedophil* OR Pederast*)</p> <p>S5 S1 OR S2 with LIMITS (Published before 2011, Human and Aged 65+)</p>	
<p>Concept 2: Older Adults</p> <p>S3 DE ("Aged (Attitudes Toward)" OR "Ageism" OR "Geriatrics" OR "Gerontology" OR "Elder Care" OR "Activities of Daily Living" OR "Life Review" OR "Geriatric Assessment" OR "Geriatric Patients" OR "Geriatric Psychiatry" OR "Geriatric Psychotherapy" OR "Geropsychology" OR "Gerontology" OR "Nursing Homes" OR "Home Care Personnel" OR "Home Care" OR "Aging in Place" OR "Long Term Care" OR "Retirement Communities" OR "Dementia" OR "Dementia with Lewy Bodies" OR "Semantic Dementia" OR "Senile Dementia" OR "Vascular Dementia" OR "Alzheimer's Disease" OR "Corticobasal Degeneration" OR "Pseudodementia")</p> <p>S4 TI("Aged 65 and over" OR "Aged(65 yrs & older)" OR "Aged 80 and over" OR "Very old(85 yrs & older)" OR "Old age" OR "Oldest old" OR "Very old" OR "Older women" OR "Older men" OR "Older adults" OR "Older aged" OR "Very old" OR "Oldest old" OR Elderly OR "Frail elderly" OR "Late life" OR "Later life" OR "Life review" OR Senior\$ OR Elder\$ OR "Homes for the aged" OR "Housing for the elderly" OR "Old age homes" OR "Nursing homes" OR "Residential aged care facilities" OR "Care homes" OR "Skilled nursing facilities" OR "Aging in place" OR "Old age psychiatry" OR "Old age psychiatrist" OR Geriatric OR "Geriatric nursing" OR Geriatrician OR Gerontolog* OR Geropsycholog* OR Psychogeriatric OR Psychogeriatrician OR Dementia OR Alzheimer's OR Alzheimers OR "Corticobasal Degeneration" OR Pseudodementia) OR AB("Aged 65 and over" OR "Aged(65 yrs & older)" OR "Aged 80 and over" OR "Very old(85 yrs & older)" OR "Old age" OR "Oldest old" OR "Very old" OR "Older women" OR "Older men" OR "Older adults" OR "Older aged" OR "Very old" OR "Oldest old" OR Elderly OR "Frail elderly" OR "Late life" OR "Later life" OR "Life review" OR Senior\$ OR Elder\$ OR "Homes for the aged" OR "Housing for the elderly" OR "Old age homes" OR "Nursing homes" OR "Residential aged care facilities" OR "Care homes" OR "Skilled nursing facilities" OR "Aging in place" OR "Old age psychiatry" OR "Old age psychiatrist" OR Geriatric OR "Geriatric nursing" OR Geriatrician OR Gerontolog* OR Geropsycholog* OR Psychogeriatric OR Psychogeriatrician OR Dementia OR Alzheimer's OR Alzheimers OR "Corticobasal Degeneration" OR Pseudodementia)</p>	
<p>S7 Combining Concept 1: Childhood Sexual Abuse AND Concept 2: Older Adults (S1 OR S2) AND (S3 OR S4) with limits Human and before 2011</p>	

Logic Matrix Search Strategy 5 – Google Scholar / Generic	
DATABASE	Google Scholar & Other GENERIC Searches
Batch processing not possible with Google Scholar, so main concepts used more simply.	
<p>Concept 1: Childhood Sexual Abuse</p> <p>("child abuse, sexual" OR incest OR "adult survivors of child abuse" OR "child sexual abuse" OR (("child abuse" OR "battered child syndrome") AND "sexual abuse") OR "childhood sexual abuse" OR "child sexual assault" OR "childhood sexual assault" OR "child sexual molestation" OR molestation OR "child abuse survivor" OR "adult survivors of sexual abuse" OR "adult survivors of sexual assault" OR Pedophile OR Paedophile OR Pederast)</p>	
<p>Concept 2: Older Adults</p> <p>"health services for the aged" OR "homes for the aged" OR "nursing homes" OR "housing for the elderly" OR geriatric OR dementia OR elderly OR aging OR senescence OR "nursing home" OR "home for the aged" OR gerontopsychiatry OR Alzheimer OR "Lewy Body" OR "aged 65 and over" OR "aged 80 and over" OR "old age" OR "oldest old" OR "very old" OR "older women" OR "older men" OR "older adults" OR "older aged" OR "older patients" OR "late life" OR "later life" OR "life review" OR "attitudes toward aging" OR "aging in place" OR "long term care" OR "retirement communities" OR "old age homes" OR "residential aged care facilities" OR "care homes" OR "skilled nursing facilities" OR gerontology OR geropsychology OR psychogeriatric OR Alzheimer's OR "Corticobasal Degeneration" OR Pseudodementia</p>	
<p>Combining</p> <p>((("child abuse, sexual" OR incest OR "adult survivors of child abuse" OR "child sexual abuse" OR (("child abuse" OR "battered child syndrome") AND "sexual abuse") OR "childhood sexual abuse" OR "child sexual assault" OR "childhood sexual assault" OR "child sexual molestation" OR molestation OR "child abuse survivor" OR "adult survivors of sexual abuse" OR "adult survivors of sexual assault" OR Pedophile OR Paedophile OR Pederast) AND ("health services for the aged" OR "homes for the aged" OR "nursing homes" OR "housing for the elderly" OR geriatric OR dementia OR elderly OR aging OR senescence OR "nursing home" OR "home for the aged" OR gerontopsychiatry OR Alzheimer OR "Lewy Body" OR "aged 65 and over" OR "aged 80 and over" OR "old age" OR "oldest old" OR "very old" OR "older women" OR "older men" OR "older adults" OR "older aged" OR "older patients" OR "late life" OR "later life" OR "life review" OR "attitudes toward aging" OR "aging in place" OR "long term care" OR "retirement communities" OR "old age homes" OR "residential aged care facilities" OR "care homes" OR "skilled nursing facilities" OR gerontology OR geropsychology OR psychogeriatric OR Alzheimer's OR "Corticobasal Degeneration" OR Pseudodementia))</p>	

Logic Matrix Search Strategy 6 - Illumina	
DATABASE	Illumina Deep Search
	<p>TI=("Aged 65 and over" OR "Aged(65 yrs & older)" OR "Aged 80 and over" OR " Very old(85 yrs & older)" OR "Old age" OR "Oldest old" OR "Very old" OR "Older women" OR "Older men" OR "Older adults" OR "Older aged" OR "Very old" OR "Oldest old" OR Elderly OR "Frail elderly" OR "Late life" OR "Later life" OR "Life review" OR Senior\$ OR Elder\$ OR "Homes for the aged" OR "Housing for the elderly" OR "Old age homes" OR "Nursing homes" OR "Residential aged care facilities" OR "Care homes" OR "Skilled nursing facilities" OR "Aging in place" OR "Old age psychiatry" OR "Old age psychiatrist" OR Geriatric OR "Geriatric nursing" OR Geriatrician OR Gerontolog* OR Geropsycholog* OR Psychogeriatric OR Psychogeriatrician OR Dementia OR Alzheimer's OR Alzheimers OR "Corticobasal Degeneration" OR Pseudodementia) OR AB=("Aged 65 and over" OR "Aged(65 yrs & older)" OR "Aged 80 and over" OR " Very old(85 yrs & older)" OR "Old age" OR "Oldest old" OR "Very old" OR "Older women" OR "Older men" OR "Older adults" OR "Older aged" OR "Very old" OR "Oldest old" OR Elderly OR "Frail elderly" OR "Late life" OR "Later life" OR "Life review" OR Senior\$ OR Elder\$ OR "Homes for the aged" OR "Housing for the elderly" OR "Old age homes" OR "Nursing homes" OR "Residential aged care facilities" OR "Care homes" OR "Skilled nursing facilities" OR "Aging in place" OR "Old age psychiatry" OR "Old age psychiatrist" OR Geriatric OR "Geriatric nursing" OR Geriatrician OR Gerontolog* OR Geropsycholog* OR Psychogeriatric OR Psychogeriatrician OR Dementia OR Alzheimer's OR Alzheimers OR "Corticobasal Degeneration" OR Pseudodementia)</p>

Appendix III Search Results

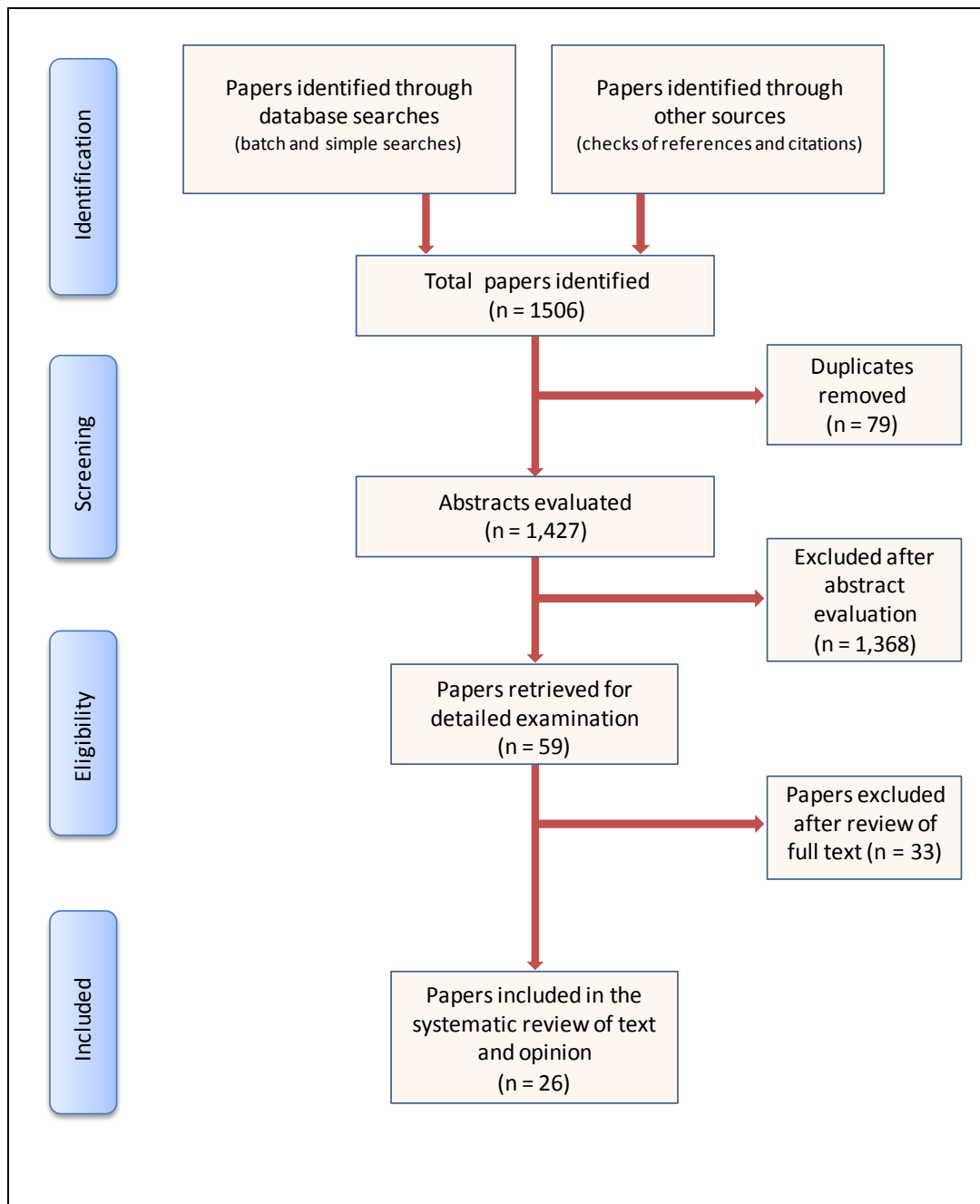


Figure 2. Flow Diagram of Study Selection (based on PRISMA statement)⁹

Appendix IV – Texts Selected for Retrieval

The 59 papers and texts that were retrieved for full text analysis for eligibility are listed below. The first section contains the texts eventually included in the narrative synthesis and the second section contains those not included, and the reasons for non-inclusion.

Texts included in the narrative synthesis

Allers, Christopher T., Benjack, Karen J., Allers, Norman T.. **Unresolved childhood sexual abuse: Are older adults affected?**. *Journal of Counseling & Development*.1992; 71(1): 14-17

Altschuler, J. and Katz, A.D.. **Sexual Secrets of Older Women**. *Clinical Gerontologist*.1996; 17(2): 51-67.

Altschuler, J. and Katz, A. D.. **Keeping your eye on the process: body image, older women, and countertransference**. *J Gerontol Soc Work*.2010; 53(3): 200-14.

Benbow, S.M. and Jagus, C.E.. **Sexuality in older women with mental health problems**. *Sexual and Relationship Therapy*.2002; 17(3): 261-270.

Bergström-Walan, Maj-Briht. **Psycho-Sexual Therapy with Elders**. *BOOK: Past Trauma in Late Life, Edited by Hunt, L., Marshall, M., Rowlings, C.*.1997; Ch. 3: 31-38.

Breitner, B.C.C. and Anderson, D.N.. **The organic and psychological antecedents of delusional jealousy in old age**. *International Journal of Geriatric Psychiatry*.1994; 9(9): 703-707.

Capasso, V. A.. **The theory is the practice: an exemplar**. *Clinical Nurse Specialist CNS*.1998; 12(6): 226-229.

Colarusso, C.A.. **The Relentless Past: The Effect of Chronic Sexual Abuse in Childhood on Fifty Years of Adolescent and Adult Development**. *BOOK: Psychoanalytic Study of the Child*.2009; 64(): 320-350.

Cruse, R.G.in Duffy, M.. **Addressing late life developmental issues for women: Body image, sexuality, and intimacy**. *BOOK: Handbook of Counseling and Psychotherapy with Older Adults*.1999; : 57-76.

Davenport, G.M.. **Working with toxic older adults: a guide to coping with difficult elders**. *BOOK: Working with Toxic Older Adults: a guide to coping with difficult elders*.1999

Duenas, Maria T.. **Impact of long term sexual abuse**. *Clinical Gerontologist: The Journal of Aging and Mental Health*.1986; 4(4): 47-50.

Fakhoury, T., Abou-Khalil, B., Newman, K.. **Psychogenic seizures in old age: a case report.** *Epilepsia*.1993; 34(6): 1049-51.

Gagnon, Michelle and Hersen, Michel. **Unresolved childhood sexual abuse and older adults: Late-life vulnerabilities.** *Journal of Clinical Geropsychology*.2000; 6(3): 187-198.
[Cites: **Allers et al**]

Gallo-Silver, L. and Weiner, M. O.. **Survivors of childhood sexual abuse diagnosed with cancer: managing the impact of early trauma on cancer treatment.** *J Psychosoc Oncol*.2006; 24(1): 107-34.

Hill, S. A.. **The man who claimed to be a paedophile.** *Journal of Medical Ethics*.2000; 26(2): 137-138.

McInnis-Dittrich, Kathleen. **Adapting life-review therapy for elderly female survivors of childhood sexual abuse.** *Families in Society*.1996; 77(3): 166-173.
[Cites: **Allers et al**]

McLean, L. M. and Hales, S.. **Childhood trauma, attachment style, and a couple's experience of terminal cancer: Case study.** *Palliative and Supportive Care*.2010; 8(2): 227-233.

Miesen, Bere M.L. and Jones, Gemma. **Psychic Pain Resurfacing in Dementia.** *BOOK: Past Trauma in Late Life, Edited by Hunt, L., Marshall, M., Rowlings, C.*.1997; Ch. 10: 142-154.

Moyer, M. S.. **Sibling relationships among older adults.** *Generations*.1992; 16(3): 55-55.

Osgood, N. J. and Manetta, A. A.. **From the world of practice. Physical and sexual abuse, battering, and substance abuse: three clinical cases of older women.** *Journal of Gerontological Social Work*.2002; 38(3): 99-113.

Resnick-Cortes, C.. **Seventy Years of Mistrust: Elderly Survivors of Sexual Abuse.** *Reflections: Narratives of Professional Helping*.2006; 12(4): 75-79
[Cites: **Allers et al, McInnes-Dittrich, Walter**]

Rosik, Christopher H.. **Geriatric dissociative identity disorder.** *Clinical Gerontologist: The Journal of Aging and Mental Health*.1997; 17(3): 63-66.

Sarkar, Jaydip.. **From science to services: Developing a neuroscience-based innovative clinical treatment model to manage severe and repetitive self-harm in a 60-year-old woman with severe personality disorders.** *Personality and Mental Health*.2010; 4(4): 302-311.

Sutton, Laura. **'Out of the Silence' - When People Can't Talk About It.** *BOOK: Past Trauma in Late Life, Edited by Hunt, L., Marshall, M., Rowlings, C.*.1997; Ch. 11: 155-170.

Wadeson, H.. **Adult Survivors of Childhood Sexual Abuse.** *BOOK: Art*
182

psychotherapy.2010; 99-104.

Walter, K.. **That was then: elderly survivors of incest.** *J Psychosoc Nurs Ment Health Serv.*1992; 30(1): 14-6.

Texts not included in the narrative synthesis and reasons

Many of the following papers and texts that were retrieved for full text scrutiny but not included in the final review were authored by very experienced health professionals and the discussions are based on their experiences. Most of these provide excellent background reading on the topic. However, after discussion with my supervisor it was decided to only include those papers with more direct reference to experience. Since I had 26 papers containing case histories, these were the papers included. To do otherwise was not possible for pragmatic reasons such as the prohibitive workload for a single reviewer as required for the award of a Master of Clinical Sciences.

The following are the papers and texts retrieved but not included, and the reasons for their non-inclusion.

Editorial Comment. **Effects of Childhood Abuse Linger into Old Age.** *J Psychosoc Nurs Ment Health Serv.* 2010; 48(11): 8-9

Summary of results presented at a conference that suggest severe childhood abuse could shorten life span by 7 to 15 years based on cytokine stress markers and telomere lengths in blood samples taken from healthy adults with a mean age of 70.

Reason for exclusion: Did not meet inclusion criteria – Not direct experience. Biological.

Various. **Ageing, dementia and adult survivors of childhood sexual assault.** *ACSSA Aware 24, Newsletter for the Australian Centre for the Study of Sexual Assault.* May 2010
www.aifs.gov.au/acssa

Discussion with a focus on dementia and elderly survivors of childhood sexual abuse. It includes an interview with Adelle Williams, a specialist aged care trainer, and a conversation between Jill Duncan, from CASA House, and Rhonda Pryor, an aged care practitioner. Rob Gordon, a clinical psychologist with 30 years experience, provides background about the nature of trauma related to childhood sexual abuse, and the relationship trajectory of ageing, memory and remembered trauma.

Reason for exclusion: Did not meet inclusion criteria – General discussion not direct experience.

Acierno, R., S. R. Lawyer, et al. **Current Psychopathology in Previously Assaulted Older Adults.** *J Interpers Violence.* 2007; 22(2): 250-258

Older adult women age 55+ years (N = 549) interviewed as part of a population-based epidemiological research study of lifetime experiences with physical and sexual assault and current mental health problems. Women who reported experiencing sexual assault an average of 50 years previously were more likely to present with autonomic arousal and avoidance symptoms of PTSD than those with no prior sexual assault.

Reason for exclusion: Did not meet inclusion criteria – Not specifically sexual abuse and age not disaggregated.

Andersen, T. H. **Men dealing with memories of childhood sexual abuse: conditions and possibilities of 'positive deviance'**. *Journal of Social Work Practice*. 2008; 22(1): 51-65

Stories of 3 men and how sexually abused men can move away from an identity formed by abuse. Participants recruited through newspaper advertisements and interviewed within a semi-structured/narrative frame. Lars 65, college professor, abused from 5 until 12-13.

Reason for exclusion: Met the inclusion criteria but only identified after the review completed.

Anetzberger, G.J. **Elderly Adult Survivors of Family Violence: Implications for Clinical Practice**. *Violence Against Women*. 1997; 3(5): 499-514

Two timeframes: early in life and elder abuse. Aged 60 years and over. Good background for cohort and cultural abuse issues.

Reason for exclusion: Did not meet inclusion criteria – Not specifically sexual abuse.

Burling, K. L. **A Correlational Investigation of the Relationship Between Psychological Distress, Life Satisfaction, and Health Care Utilization Among Elderly Male Inmates. US**, *ProQuest Information & Learning*. 2000; 60

Participants 55 to 80. Interviewed, assessed for psychological distress, and asked to evaluate current life satisfaction.

Reason for exclusion: Did not meet inclusion criteria – Unable to obtain dissertation.

Butler, R., M. Lewis, et al. **Love and Sex After 60: How To Evaluate and Treat the Sexually-Active Woman**. *Geriatrics*. 1994; 49(11): 33

Panel Discussion conducted by Dr Butler. Dr Hoffman – the primary care physician needs to ask patients about a history of sexual and physical abuse as routinely as asking about chest pain or indigestion. I'm shocked to see the prevalence of childhood abuse among women in my practice.

Reason for exclusion: Did not meet inclusion criteria – Considered but excluded, minimal information.

Carr, A., Dooley, B., Fitzpatrick, M., et al. **Adult adjustment of survivors of institutional child abuse in Ireland**. *Child Abuse & Neglect*. 2010; 34; 477-489

247 adult survivors of institutional abuse with mean age of 60 (40-83yrs). 47% had experienced sexual abuse within institutions.

Reason for exclusion: Did not meet inclusion criteria – No age disaggregation

Cook, J.M. and O'Donnell, C. **Assessment and Psychological Treatment of Posttraumatic Stress Disorder in Older Adults**. *Journal of Geriatric Psychiatry and Neurology*. 2005; 18(2):61-70

Summary of the literature. Evidence for treatment almost non-existent, but there are innovative clinical endeavours.

Reason for exclusion: Did not meet inclusion criteria – Not specifically about childhood sexual abuse.

Cites: McInnes-Dittrich

Davy, E. **The Endoscopy Patient with a History of Sexual Abuse: Strategies for Compassionate Care.** *Gastroenterology Nursing.* 2006; 29(3): 221

This article reviews the need for careful assessment and intervention during endoscopy procedures for patients with a past history of abuse. Guidelines for compassionate care and follow-up are discussed.

Reason for exclusion: Did not meet inclusion criteria – Either age too young or not childhood abuse

Draper, B., Pfaff, J.J., Pirkis, J., et al. **Long-Term Effects of Childhood Abuse on the Quality of Life and Health of Older People: Results from the Depression and Early Prevention of Suicide in General Practice Project.** *JAGS.* 2008; 56: 262-271

Important large scale study (more than 21,000 older adults > 60) 6.5% reported childhood sexual abuse. 80+ had lowest prevalence.

Reason for exclusion: Did not meet inclusion criteria – Not direct experience.

Farris, M. and Gibson, J.W. **The Older Woman Sexually Abused as a Child.** *Journal of Women & Aging.* 1993; 4(3): 31-44

Selectively reviews what is known for younger women. PTSD is suggested as a model for describing the effects on older women. Gives implications for practice.

Reason for exclusion: Did not meet inclusion criteria – Discussion paper, no direct experience.

Flannery, R. B. **Restraint Procedures and Dementia Sufferers with Psychological Trauma.** *American Journal of Alzheimer's Disease and Other Dementias.* 2003; 18(4): 227

Restrained patients may be victims of violence for whom the restraint procedure acts as a symbolic remainder of the past victimisation. Gives an overview of taking assessing for a trauma history eg ask family, changes in behaviour, review number of lifetime addictions.

Reason for exclusion: Did not meet inclusion criteria – Review of literature and discussion.

Cites: Allers et al

Gentlewarrior, S. **Symptoms of Trauma in Middle-Aged and Older Female Survivors of Child Sexual Abuse: An Ecological Examination of Risk and Protective Factors.** US, ProQuest Information & Learning. 1998; 59

Informative Ecological study (whole beings embedded in social & historical contexts). Nonclinical sample of 2 cohorts (29-59yrs) and (60-90 yrs). Used a self-administered mailed questionnaire. Used professional women.

Reason for exclusion: Did not meet inclusion criteria – No direct experience

Haugebrook, S., K. M. Zgoba, et al. **Trauma, Stress, Health, and Mental Health Issues Among Ethnically Diverse Older Adult Prisoners.** *Journal of Correctional Health Care.* 2010; 16(3): 220

Study where data was collected using case record reviews of 114 prisoners aged 55 or older, mean age 55.5.. Most had childhood or adult trauma. Health status in their 50's is equivalent to non-prisoners in their 70's.

Reason for exclusion: Did not meet inclusion criteria – Study with no direct experience, age not disaggregated

Higgins, A. B. and Follette, V. M. **Frequency and Impact of Interpersonal Trauma in Older Women.** *Journal of Clinical Geropsychology.* 2002; 8(3): 215-226

A study that investigates the relationship between a history of interpersonal trauma and subsequent adjustment difficulties in women over 60.

Reason for exclusion: Did not meet inclusion criteria – Not specifically childhood sexual abuse.

Cites: **Allers et al**

Joseph, C. G. and Rose, M. K. **Female Incest Survivors: Caregiving for Aging Parents.** *Journal of Women & Aging.* 1994; 6(3): 53-68

In-depth interviews by the author of 14 women incest survivors aged 40 to 61. The analysis identified 5 caregiving avoidance strategies. Interesting insight.

Reason for exclusion: Did not meet inclusion criteria – Unable to disaggregate ages

Kok, R. M., A. H. Matthijsen, et al. **[Psychic Consequences on the Elderly of Sexual Abuse in Their Youth].** *Ned Tijdschr Geneeskde.* 2005; 149(17): 905-908

Three women aged 64, 65 and 60 admitted for psychopathology revealed for the first time that they had been sexually abused as a child by a relative. Unfortunately the author could not provide an English translation. I used Google Translate which was successful but because my input was required to make choices between translated words I could not use the paper.

Reason for exclusion: English abstract, Non-English paper provided by author [Google Translate somewhat successful].

Cites: **Walter**

Krause, N. **Traumatic events and meaning in life: exploring variations in three age cohorts.** *Ageing & Society* 25, 2005, 501-524

Important background paper. Continuing longitudinal study; examines the relationship between traumatic events that arise across the lifecourse and a sense of meaning in later life. Uses 3 age cohorts: the young-old, the old-old and the oldest-old.

Reason for exclusion: Did not meet inclusion criteria – Not specifically childhood sexual abuse

Lange, A., E. de Beurs, et al. **Long-term Effects of Childhood Sexual Abuse: Objective and Subjective Characteristics of the Abuse and Psychopathology in Later Life.** *J Nerv Ment Dis.* 1999; 187(3): 150-158

Study investigates the association between childhood sexual abuse and psychopathology in later life. Sample of 404 Dutch females aged 18 to 84. Good background paper.

Reason for exclusion: Did not meet inclusion criteria – strange age range for Later Life – no disaggregation.

Macpherson, C. **Childhood Abuse Uncovered in a Palliative Care Audit.** *Palliative and Supportive Care.* 2009; 7(04): 481-486

Although the study includes grandparents, they were not reported on in this paper. Interesting background paper.

Reason for exclusion: Did not meet inclusion criteria – Participants too young

Monahan, K. **Death of an Abuser: Does the Memory Linger On?** *Death Studies.* 2003; 27: 641-651

A case study that examines the reactions, themes and attributions that individuals experience regarding the loss of a relative who was sexually abusive to them during childhood. Good background paper.

Reason for exclusion: Did not meet inclusion criteria – Case too young at 52.

Monahan, K. Themes of Adult Sibling Sexual Abuse Survivors in Later Life: An Initial Exploration. *Clinical Social Work Journal*. 2010; 38(4): 361-369

Paper examines treatment issues in a small, clinical practice setting by 8 women aged 56 to 69 who were sexually abused by their brothers during childhood. Interesting paper.

Reason for exclusion: Did not meet inclusion criteria – Clinical sample could not disaggregate ages

Cites: **Gagnon et al**

Mullan, E. and Orrell, M. Early Life Experience in Elderly Women with a History of Severe Depression: A Pilot Study Using the Brief Parenting Interview. *Irish Journal of Psychological Medicine*. 1996; 13: 18-20

The majority of elderly women (71%) with a history of severe depression had suffered significant childhood trauma. Eight (57%) women reported parental loss, six (49%) reported tension or discord in the family home and one woman reported severe child sexual abuse.

Reason for exclusion: Did not meet inclusion criteria – Not specifically childhood sexual abuse.

Peters, J. and Kaye, L. W. Childhood Sexual Abuse: A Review of Its Impact on Older Women Entering Institutional Settings. *Clinical Gerontologist*. 2003; 26(3/4): 29-53

Seminal background paper – extensive review of the literature. Offers analysis of the ways in which aging and the organisational practices of long-term care institutions may serve to reactivate and exacerbate long-dormant childhood sexual abuse issues.

Reason for exclusion: Did not meet inclusion criteria – Discussion, direct experience not cited

Cites: **Allers et al, Gagnon et al, Walter and Gentlewarrior**

Reich, F. From Fantasy to Dementia: The Misdiagnosis and Mistreatment of Older Adult Women Living in Nursing Homes with a History of Untreated or Undisclosed Childhood Sexual Abuse. *US, ProQuest Information & Learning*. 1997;57

Study based on the premise that older adults are less likely to be diagnosed with PTSD. Subjects given 1 of 2 vignettes, one where the client was aged 30 and the other aged 70. Unfortunately the power of the study was too low to statistically detect a difference. There is a small paragraph; pages 113-114, that is direct experience in a nursing home.

Reason for exclusion: Did not meet inclusion criteria – Primarily a study based on vignettes

Cites: **Allers et al and Walter**

Sheikh, J. I., Swales, P. J. et al. Childhood Abuse History in Older Women with Panic Disorder. *The American Journal of Geriatric Psychiatry*. 1994; 2(1): 75-77

24 subjects in a clinical trial of older panic disorder patients. Ages 55-73 but no disaggregation

Reason for exclusion: Did not meet inclusion criteria – small sample study with no disaggregation of ages.

Somer, E. Effects of Incest in Aging Survivors: Psychopathology and Treatment Issues. *Journal of Clinical Geropsychology*. 2000; 6(1): 53-61

Important background discussion paper highlighting PTSD and treatment issues with older adult survivors

Reason for exclusion: Did not meet inclusion criteria – Discussion paper no direct experience cited.

Talbot, N. L., Duberstein, P. R., et al. **Preliminary Report on Childhood Sexual Abuse, Suicidal Ideation, and Suicide Attempts Among Middle-Aged and Older Depressed Women.** *American Journal of Geriatric Psych.* 2004; 12(5): 536

Authors examined the relationship between childhood sexual abuse histories and suicidal ideation and behaviour among depressed women age 50 years and older.

Reason for exclusion: Did not meet inclusion criteria – Lower age < 60 and no major disaggregation

Talbot, N. L., Chapman, B., et al. **Childhood Sexual Abuse is Associated with Physical Illness Burden and Functioning in Psychiatric Patients 50 years of Age and Older.** *Psychosom Med.* 2009; 71(4): 417-422

A study of 163 psychiatric patients aged ≥50yrs with primary mood disorders via interviews and chart reviews.

Reason for exclusion: Did not meet inclusion criteria – Lower age < 60 and no major disaggregation

Whitfield, C. L. **Internal Verification and Corroboration of Traumatic Memories of Child Sexual Abuse.** *Journal of Child Sexual Abuse.* 1997; 6(3): 99 – 122

Based on clinical experience and review of the clinical and legal research literature the author proposes that a cluster of several of 6 clinical findings is a potential indicator of internal corroboration that trauma occurred, especially childhood sexual abuse. Useful paper.

Reason for exclusion: Did not meet inclusion criteria – Age criteria not met.

Wolkenstein, B.H. and Sterman, L. **Unmet Needs of Older Women in a Clinic Population: The Discovery of Possible Long-Term Sequelae of Domestic Violence.** *Professional Psychology: Research and Practice.* 1998; 29(4): 341-348

Older women presenting to 2 community mental health centres. Increased media attention to domestic violence often preceded first-time disclosure of abuse. Case Study 2 – 63 yr old woman born in Puerto Rico. In later sessions disclosed childhood sexual abuse.

Reason for exclusion: Met the inclusion criteria but missed during the retrieval process.

Wygant, C., Hui, D., Bruera, E. **Childhood Sexual Abuse in Advanced Cancer Patients in the Palliative Care Setting.** *Journal of Pain and Symptom Management.* 2011

The long-term effects of childhood sexual abuse can have a significant impact on patients' quality of life, particularly at the end of life. Very important paper.

Reason for exclusion: Did not meet inclusion criteria – Outside time period for inclusion, otherwise would have been included.

Cites: **Gallo-Silver et al**, MacPherson, C.,

Appendix V - Appraisal of Selected Texts

Criteria	Yes	No	Unclear	Not applicable
1) Is the source of the opinion clearly identified?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2) Does the source of the opinion have standing in the field of expertise?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3) Are the interests of patients/clients the central focus of the opinion?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4) Is the opinion's basis in logic/experience clearly argued?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5) Is the argument developed analytical?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6) Is there reference to the extant literature/evidence and any incongruency with it logically defended?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7) Is the opinion supported by peers?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Figure 3 NOTARI Critical Appraisal Instrument

NOTARI Table 1. NOTARI Summary Appraisal of Included Texts							
Text #	Q1	Q2	Q3	Q4	Q5	Q6	Q7
1	Y	Y	Y	Y	Y	Y	Y
2	Y	Y	Y	Y	Y	Y	U
3	Y	Y	Y	Y	Y	Y	Y
4	Y	Y	Y	N	N	N	Y
5	Y	Y	Y	Y	Y	U	U
6	Y	Y	U	Y	N/A	Y	Y
7	Y	Y	Y	U	Y	Y	U
8	Y	Y	Y	Y	Y	Y	U
9	Y	Y	Y	Y	Y	Y	U
10	Y	Y	Y	N	N	Y	N
11	Y	U	Y	U	N/A	N/A	N/A
12	Y	Y	Y	Y	Y	Y	Y
13	Y	Y	Y	Y	Y	Y	Y
14	Y	Y	Y	Y	Y	Y	Y
15	Y	Y	Y	Y	N/A	N	N/A
16	Y	Y	Y	Y	Y	Y	Y
17	Y	Y	Y	Y	Y	Y	U
18	Y	Y	Y	Y	Y	Y	U
19	Y	Y	Y	Y	Y	Y	U
20	Y	Y	Y	Y	Y	Y	Y
21	Y	Y	Y	Y	Y	N	U

NOTARI Table 1. NOTARI Summary Appraisal of Included Texts							
Text #	Q1	Q2	Q3	Q4	Q5	Q6	Q7
22	Y	Y	Y	Y	N/A	N	U
23	Y	Y	Y	Y	Y	Y	U
24	Y	Y	Y	Y	Y	Y	U
25	Y	Y	Y	Y	Y	N	Y
26	Y	Y	Y	Y	U	Y	U
%	100.0	96.15	96.15	84.62	86.36	76.0	41.67
Text # - is the unique number assigned to each text in Master Table 1 in Appendix I							

Appendix VI - Data Extraction from Included Texts

Extraction Details: Extraction - Name (2011)

* denotes field which will appear in report appendix

Type of Text:

Those Represented: *

Stated Allegiance/Position:

Setting:

Geographical:

Cultural:

Logic of Argument: *

Data Analysis:

Authors Conclusion: *

Reviewers Comments: *

Complete

Figure 4 NOTARI Data Extraction Instrument

NOTARI Table 2. NOTARI Summary of Included Papers				
#	Represented	Logic of Argument	Stated Allegiance/Position	Reviewer's Comments
1	Older adults affected by unresolved childhood sexual abuse.	Clear argument, well illustrated by case examples and supported by extant literature.	The residual effects they see in their practice are not just the effects of advanced age but are lifelong in nature and could stem from unresolved childhood sexual abuse.	Seminal article much cited. The illustration that shows one older person misdiagnosed with dementia is often given more generalisable significance than is warranted in citing papers.
Main Conclusion/Theme: Chronic depression, the misdiagnosis of residual abuse trauma as dementia or mental illness, and re-victimization continue to plague older adults and disrupt their ability to function independently.				
2	Older women and the therapists working with them.	Clear, logical, supported by extant literature.	There is a gap in the literature regarding countertransference and sexuality and older women.	Incest is only one of the topics included in the paper. All attempts have been made to relate the conclusions only back to this section.
Main Conclusion/Theme: Societal expectations, misinformation, personal prejudice and values and lack of training are conscious issues. Conscious issues might prevent the exploration of sexual issues among older women; countertransference makes it virtually impossible.				
3	Older women and the therapists working with them.	Clear, conclusions supported.	Whether social worker or client, most women are affected by societal standards and conceptualizations of attractiveness.	The paper contains seven case examples but only one relates to childhood sexual abuse. The conclusions are wherever possible, related back to this one case study.

NOTARI Table 2. NOTARI Summary of Included Papers				
#	Represented	Logic of Argument	Stated Allegiance/Position	Reviewer's Comments
Main Conclusion/Theme: Until practitioners, educators, and researchers begin to address the intersection of body image concerns of older women and countertransference, the potential mental health concerns of older women and body image may be stereotypically addressed, considered insignificant, or overlooked.				
4	Elderly women with mental health problems.	The example used to specifically illustrate depression causing sexual dysfunction is not ideal for the chosen topic.	The recognition, assessment and treatment of sexual dysfunction in elderly women with mental health problems may improve their quality of life.	Rather than an illustration of depression and sexual dysfunction, this case illustrates how childhood sexual abuse might contribute to sexual dysfunction in later life.
Main Conclusion/Theme: Sexual dysfunction may occur at any age and is often unacknowledged or disregarded for older people with psychiatric disorders, by their families/carers and by health professionals.				
5	Elders and the therapist working with them.	Clear, conclusions supported.	Uses therapy based on psychodynamic-orientated psychotherapy combined with theory and techniques from primal therapy and hypnotherapy.	Well argued especially about the historical reason that women did not seek counselling.
Main Conclusion/Theme: In late life it is not too late to use psychotherapy to help resolve old and still seriously inhibiting and painful problems which stem from traumatic experiences in early life.				
6	The elderly.	Basic case study description with minimal analysis.	There may be apparently common organic and psychological antecedents of delusional jealousy in old age.	Seven case studies described but only one relevant to the review. Very basic description.
Main Conclusion/Theme: Early childhood experiences of sexual trauma may have direct relevance to the later delusions associated with organic brain disease				
7	Nurse-patient therapeutic relationship.	Discussion logical within the contextual framework chosen, but may be forcing the argument into the context and not considering other explanations. Jargonistic and hyperbolic.	Newman's Theory of Health as Expanding Consciousness can provide the framework for a paradigm shift from a curative to a healing practice of nursing.	Although her argument is often overshadowed by her passion; the conclusions are relevant and very important for care.
Main Conclusion/Theme: Based on a theoretical framework of Expanding Consciousness, nursing practice can shift the focus of care from the efficient completion of tasks to healing the whole person.				
8	Sisters repeatedly sexually abused by a Catholic priest.	Clear, contextual, extensive evaluation and discussion, conclusions supported.	Psychoanalytical perspective - based on a single interview and psychological testing conducted for use in a legal process.	Important paper by an experienced psychoanalyst and Clinical Professor of Psychiatry to further understanding of the lifelong damage done by childhood sexual abuse.
Main Conclusion/Theme: Childhood sexual abuse can have profound negative effects on all major developmental tasks over the entire life course, including late adulthood.				
9	Older women	Clear, grounded in own practice, well referenced	Uses life review combined with Gestalt techniques to assist women with late life developmental issues.	While only a small part of the chapter it highlights the complexity of relationships and the importance of looking beneath the surface of a problem.

NOTARI Table 2. NOTARI Summary of Included Papers				
#	Represented	Logic of Argument	Stated Allegiance/Position	Reviewer's Comments
Main Conclusion/Theme: A sexual history is an important part of life review therapy for older women when addressing late life developmental issues.				
10	Older woman college student, fellow students and teachers	Clear, well told, supported by extensive theoretical discussion.	Motivated by her interest in successful aging and the small percentage (albeit a large number) of older adults who are not aging successfully.	Entertaining but academically scrupulous in the various theories explained and illustrated in her arguments. While "toxic" may seem a derogatory term it nonetheless provokes as it provides a mental picture of those clients that are most challenging.
Main Conclusion/Theme: By identifying this aging anomaly, labelling it to understand the pattern and what we are dealing with, working with possible causes rather than symptoms, proposing some strategies for coping, and suggesting ways to prevent its occurrence, it is hoped this Victim consciousness and negativity cycle can be interrupted before the baby boomers reach their late 70s.				
11	Older women	A simple description of the case of one woman, with no analysis beyond this individual	No studies that I am aware of have been made on the effect of sexual abuse on persons in their seventh decades. This case study is just one instance of such effects.	Simple insightful telling of a clinical case
Main Conclusion/Theme: Isolation, depression and low self-esteem are the most obvious results of long term sexual abuse in this case, and although she has come a long way, she still has not come to terms with her feelings of guilt, anger and aloneness.				
12	Older women	Clear medical, psychological evaluation. Well referenced.	Although rare in those over 60, psychogenic seizures should be considered in elderly patients.	One case study that illustrates a possible mind body connection with childhood sexual abuse in an older adult with current turmoil.
Main Conclusion/Theme: Psychogenic seizures may begin in old age and should be considered in the differential diagnosis of intractable seizures in the elderly.				
13	Older adults	Clear arguments, well referenced and conclusions well supported by examples and extant literature.	Given the paucity of information about late-life problems with unresolved childhood sexual abuse, the purpose of this paper is to examine predisposing variables and late-life stressors that place older adult survivors at psychological risk.	Very good background and overview paper.
Main Conclusion/Theme: Two observed stressors (loss of social support and declining health) and one developmental task (reminiscence or life-review) appear to be linked to exacerbated vulnerabilities in older survivors. These vulnerabilities may exacerbate unresolved childhood sexual abuse, particularly when the adult encounters stressors or developmental tasks that exceed his or her capacity for adaptive coping.				
14	Older adult cancer patients	Clear, in depth, well referenced, conclusions supported.	Survivors of childhood sexual abuse diagnosed with cancer are presented with multiple and potentially accumulating traumas.	Important article providing an insight into a generally unrecognised aspect of cancer care.
Main Conclusion/Theme: Health care/psychosocial clinicians awareness and use of appropriate interventions can minimize the effects of re-traumatization [of a cancer diagnosis and treatment] and enhance the CSA survivors treatment experience.				

NOTARI Table 2. NOTARI Summary of Included Papers				
#	Represented	Logic of Argument	Stated Allegiance/Position	Reviewer's Comments
15	An older man	Simple coalface case presentation, no analysis or referencing.	There can be complex ethical dilemmas regarding confidentiality and protection of the public (and animals).	Provides an insight into the ethical dilemmas confronting the frontline clinician when faced with a patient with complex needs that may affect public safety.
Main Conclusion/Theme: Complex ethical dilemmas can occur during the clinical management of persons who may have sexually abused children in the past.				
16	Four older rural Appalachian women	Clear arguments. Themes and conclusions well supported by extant literature and case descriptions.	Skilled application of the techniques of formal life review may resolve lifelong conflicts, helping older persons find fulfilment in their remaining years.	Interesting article that highlights one particular form of psychotherapy adapted for use with older clients. Not stated how the author; an academic, was involved with the cases described.
Main Conclusion/Theme: Therapists must take great care to preserve functional defense mechanisms for the survivor, utilize nonverbal techniques to process intense feelings and assist in the memory retrieval process, and incorporate creative techniques to address family-of origin issues.				
17	An older woman with terminal cancer and her spouse	Clear argument, conclusions well supported by extant literature and descriptive analysis of the case	The authors endorse the benefits of: 1) a clinical focus on the marital unit informed by an understanding of trauma and attachment needs; 2) provision of end-of-life care with a multidisciplinary health care team approach; 3) realistic clinical goals with a focus on tolerance of distress rather than an idealized death without distress.	Provides many insights including the importance of psychosocial care in the palliative care setting.
Main Conclusion/Theme: Illuminates the potential effectiveness of a modified EFT [Emotionally Focused couple Therapy] protocol, and underscores the need to both identify and intervene with a population potentially at significantly high risk for marital distress, suicidality, depression, and hopelessness.				
18	Older people with dementia.	Clear, well argued and conclusions well supported.	Dementia can be understood within a trauma framework.	Essential reading for those working with people with dementia. A significant discussion of the relationship of trauma and dementia with good recommendations for interventions.
Main Conclusion/Theme: It is our challenge to understand dementia syndrome as the beginning of a new chronic trauma which, for some elderly people, is heightened and intensified by the return of trauma from the past.				
19	Older adult siblings	Discussion paper based on professional experience with some supportive referencing.	This paper is not intended as a research report or an exhaustive review of professional literature but is based on professional observations made in more than 20 years as a multigenerational therapist.	Not an analytical paper but does provide insight into another important aspect of older survivors support network; same generation siblings.
Main Conclusion/Theme: The opening up of this family secret allowed the siblings to support and finally to get to know each other as they worked on their individual and family healing.				

NOTARI Table 2. NOTARI Summary of Included Papers				
#	Represented	Logic of Argument	Stated Allegiance/Position	Reviewer's Comments
20	Older women	Clear, logical, well referenced.	While there are retrospective studies on the experiences of adult women who suffered abuse in the family, little is known about the experiences of women over the age of 60 years.	Very tragic lady that is illustrative of the difficulties faced by health professionals uncovering such trauma especially in the very elderly.
Main Conclusion/Theme: The primary role of the social worker is to be comfortable with the silence that surrounds disclosure of abuse, and then allow the survivor to reveal small amounts of information at a time, to explore the factors contributing to their problems.				
21	Older women	Discussion grounded in personal experience with appropriate reference to extant literature.	Incorporates faith, the spiritual, and the religious into her practice, her teaching and her personal life when appropriate and possible.	A very moving, experientially informative paper that exposes moments of uncaring care that must be addressed.
Main Conclusion/Theme: Women can live full lives that take them way beyond their abuse and health professionals can learn from them and continue to learn, grow, and develop regardless of many years of experience.				
22	Older woman	Not an analytic paper rather a case report with some discussion.	The findings of this case report make clear that geriatric dissociative identity disorder exists and may not be as unusual as the silence of the contemporary literature implies.	Compelling case report that provides insight into what may be missed by health professionals and the consequences for the patient and tax payer.
Main Conclusion/Theme: Health professionals can misinterpret the symptoms of a dissociative disorder that may manifest in physical expressions of emotional distress [somatoform dissociation], resulting in unnecessary medical and surgical interventions over many years.				
23	An older woman with highly complex needs, and the team of health professionals involved in her care.	Theoretically based, clear well argued and supported by empirical evidence and extant literature.	There is a need for development of new models of care for management of patients with a combination of Repetitive Self Harm (RSH), violence to others and institutionalization.	May be simpler explanations for improvement apart from the theoretical model described e.g. empowerment of staff with a plausible, structured model of care so that they approached the treatment with a more positive attitude.
Main Conclusion/Theme: The main focus of management of Repetitive Self Harm stemmed from a team understanding, as opposed to the understanding of one 'special' therapist, within an easy to understand, simple, flexible, and responsive approach that did not burden clinicians and patient with 'heavy' theory and technical jargon, thus making it user-friendly.				
24	An elderly woman and the staff in her rest home.	Told in a narrative style, but nonetheless logical, clear, incisive and well referenced.	A particular interest in the psychology of memory, depression and dementia in old age.	A beautiful story of how support at all levels can aid coping and healing. Should be read by all those working in aged care.
Main Conclusion/Theme: Some people cannot talk about it because they do not know what 'it' is. How can someone talk about that which is much bigger than they; about experiences that were never constructed or acknowledged by society but which hurt them so badly. People can, however, say or show that 'it' hurts.				

NOTARI Table 2. NOTARI Summary of Included Papers				
#	Represented	Logic of Argument	Stated Allegiance/Position	Reviewer's Comments
25	Older male survivor of childhood sexual abuse	Simply and clearly told, case description with some discussion and examples of the client's art work. The case of a man was deliberately chosen because the literature is replete with women cases.	Approach is humanistic, existential, and phenomenological and considers psychotherapy as primarily an educational process to help people with problems in living rather than as a treatment for disease.	Concise but illustrative case example from a very experienced art psychotherapist.
Main Conclusion/Theme: For males, art therapy may be a more congenial way of relating and expressing themselves than simply talking. Art-making may provide insight into anger and low self-esteem that grew out of an abusive background.				
26	Older women survivors of incest	Early paper. Clear, well argued based on personal experience, with appropriate reference to extant literature of the time.	Once believed that incest was a product of more modern times until she worked with elderly survivors of incest on a geriatric psychiatry unit. Approaches the issues from a developmental perspective.	Early paper often cited. Not much has changed in nearly 20 years. Treatment issues not referenced probably because there were none. Paragraph on background abridged with referencing but no discussion because related to younger age groups.
Main Conclusion/Theme: Assessment of geriatric patients to determine their possible status as incest survivors is important for understanding presenting symptoms and interpersonal dynamics.				
# - Refers to Title Number for the Text in Master Table 1 in Appendix 1.				

References

1. The Joanna Briggs Institute. SUMARI User Guide Version 4.0. In: Pearson A, editor. 2007.
2. Munro I, Randall J. 'I Don't Know What I'm Doing, How About You?': Discourse and Identity in Practitioners Dealing with the Survivors of Childhood Sexual Abuse. *Organization*. 2007;14(6):887-907.
3. Hunter SV. Beyond Surviving Gender Differences in Response to Early Sexual Experiences With Adults. *Journal of Family Issues*. 2009;30(3):391-412.
4. Australian Women's Coalition. Happy Healthy Women Not Just Survivors Consultation Report. 2010.
5. Herman JL. Trauma and Recovery. New York, NY: Basic Books; 1997.
6. Hyer L. The Effects of Trauma: Dynamics and Treatment of PTSD in the Elderly. In: Edited by Duffy M, editor. Chapter 32 in Handbook of Counseling and Psychotherapy with Older Adults 1999. p. 539-553.
7. Morrison Z, Quadara A, Boyd C. "Ripple effects" of sexual assault. ACSSA Issues 2007; 7(June): Available from: www.aifs.gov.au/acssa.
8. Knight BG. Psychotherapy With Older Adults. 3rd edition. SAGE Publications Inc.; 2004.
9. Liberati A, Altman DG, Tetzlaff J, Mulrow C, Gotzsche PC, Ioannidis JPA, et al. The PRISMA Statement for Reporting Systematic Reviews and Meta-Analyses of Studies That Evaluate Health Care Interventions: Explanation and Elaboration. *PLoS Medicine* 2009; 6(7).
10. Fergus L, Keel M. Adult victim/survivors of childhood sexual assault, Australian Centre for the Study Of Sexual Assault, Australian Institute of Family Studies, (ACSSA Wrap No 1). 2005; November. Melbourne, Victoria. 2005.
11. Finkelhor D. The international epidemiology of child sexual abuse. *Child Abuse & Neglect*. 1994;18:409-417.
12. Havig K. The health care experiences of adult survivors of child sexual abuse: A systematic review of evidence on sensitive practice. *Trauma, Violence, & Abuse*. 2008 January;9(1):19-33.
13. Draper B, Pfaff JJ, Pirkis J, Snowdon J, Lautenschlager NT, Wilson I, et al. Long-term effects of childhood abuse on the quality of life and health of older people: results from the Depression and Early Prevention of Suicide in General Practice Project. *Journal of the American Geriatrics Society*. 2008;56(2):262-271.

14. UNICEF Demographic Profiles.
www.unicef.org/infobycountry/nigeria/nigeria_statistics.html.
15. Ageing Social Policy and Development Division United Nations. 2012.:
<http://social.un.org/index/Ageing/DataonOlderpersons.aspx>.
16. Gureje O, Afolabi E. Epidemiology of major depressive disorder in elderly Nigerians in the Ibadan Study of Ageing: a community-based survey. . The Lancet. 2007;September(370):957-964.
17. Oladeji BD, Makanjuola VA, Gureje O. Family-related adverse childhood experiences as risk factors for psychiatric disorders in Nigeria. Br J Psychiatry. 2010 Mar;196:186-191.
18. Gaitz CM. Barriers to the delivery of psychiatric services to the elderly. The Gerontologist. 1974;June:210-214.
19. Cuijpers P, van Straten A, Smit F. Psychological treatment of late-life depression: a meta-analysis of randomized controlled trials. International Journal of Geriatric Psychiatry. 2006(21):1139-1149.
20. Peters J, Kaye LW. Childhood sexual abuse: a review of its impact on older women entering institutional settings. Clinical Gerontologist. 2003;26(3/4):29-53.
21. Eastaerl P. "Survivors of sexual assault: A national survey", in P. Eastaerl (ed.), Without Consent: Confronting Adult Sexual Violence, Proceedings of a Conference; Australian Institute of Criminology, Canberra. 1992. p. 27-29.
22. Holmes GR, Offen L, Waller G. See no evil, hear no evil, speak no evil: why do relatively few male victims of childhood sexual abuse receive help for abuse-related issues in adulthood? Clinical Psychology Review. 1997;17(1):69-88.
23. Hodges EA, Myers JE. Counseling adult survivors of childhood sexual abuse: benefits of the wellness approach. Journal of Mental Health Counseling. 2010, April;32(2):139-154.
24. ABS. Australian Bureau of Statistics, Cat. No. 2068.0 – 2006 Census Tables, 2006 Census of Population and Housing Australia. Country of Birth (Region) of Person by Age by Sex. Based on place of Usual Residence.
25. Kong E, Deatrick J, Evans L. The experiences of Korean immigrant caregivers of non-english speaking older relatives with dementia in American nursing homes. Qualitative Health Research. 2010;20(3):319-329
26. Krug EG. World report on violence and health. Geneva, World Health Organization (WHO). 2002.

27. Rush F. Best Kept Secrets-Sexual Abuse of Children, Book Abstract (Prentice Hall) NCJRS – National Criminal Justice Reference Service, US Department of Justice. 1980.
28. Neame A, Heenan M. What lies behind the hidden figure of sexual assault? Issues of prevalence and disclosure, ACSSA Briefing Paper No. 1, Australian Centre for the Study Of Sexual Assault, Australian Institute for Family Studies, Melbourne. 2003.
29. Klafter N. The impact of childhood sexual abuse. Paper submitted to the Jewish Board of Advocates for Children September 21. 2008.
30. Alzheimers Disease International paper, London 2008. www.alz.co.uk.
31. Russell DEH. The prevalence and seriousness of incestuous abuse: Stepfathers vs. biological fathers. Child Abuse and Neglect. 1984(8):15-22.
32. Faller K. The role relationship between victim and perpetrator as a predictor of characteristics of intrafamilial sexual abuse. Child and Adolescent Social Work. 1989(6):217-229.
33. Mullen PE, Martin JL, Anderson JC, Romans SE, Herbison GP. The long-term impact of the physical, emotional and sexual abuse of children: a community study. Child Abuse and Neglect. 1996(20):7-21.
34. Lamont A. Effects of child abuse and neglect for adult survivors. Australian Institute of Family Studies, National Child Protection Clearinghouse Resource Sheet. 2010, April.
35. Mouzos J, KMakkai T. Women's Experiences of Male Violence: Findings from the Australian Component of the International Violence Against Women Survey (IVAWS), Australian Institute of Criminology Research and Public Policy Series No. 56; downloaded November 22, 2004.
36. Denov M. The long-term effects of child sexual abuse by female perpetrators: A qualitative study of male and female victims. Journal of Interpersonal Violence. 2004, October;19(10):1137-1156.
37. Cattal H. Suicide in the elderly. Advances in Psychiatric Treatment. 2000(6):102-108.
38. Gordon R. Ageing, dementia and adult survivors of childhood sexual assault . Australian Centre for the Study of Sexual Assault, Australian Institute of Family Studies. 2010, ACSSA Aware 24.
39. Schachter CL, Stalker CA, Teram E, Lasiuk GC, Danilkewich A. Handbook on sensitive practice for health care practitioners: Lessons learned from adult survivors of childhood sexual abuse. Ottawa: Public Health Agency of Canada. 2009.

40. Ballard CG, Gauthier JL, Cummings JL, Brodaty H, Grossberg GT, Robert P, et al. Management of agitation and aggression associated with Alzheimer disease. *Nature Reviews Neurology* 2009, May; Vol 5: 245-255. 2009, May;5:245-255.
41. Cook JM, O'Donnell MA. Assessment and psychological treatment of posttraumatic stress disorder in older adults. . *Journal of Geriatric Psychiatry and Neurology*. 2005, June;18(2):61-71.
42. The Joanna_Briggs Institute. Joanna Briggs Institute Reviewers' Manual: 2008 edition. In: Pearson A, editor
43. Benbow SM, Jagus CE. Sexuality in older women with mental health problems. *Sexual and Relationship Therapy*. 2002;17(3):261-270.
44. Breitner BCC, Anderson DN. The organic and psychological antecedents of delusional jealousy in old age. *International journal of geriatric psychiatry*. 1994;9(9):703-707.
45. Fakhoury T, Abou-Khalil B, Newman K. Psychogenic seizures in old age: a case report. *Epilepsia*. 1993 Nov-Dec;34(6):1049-1051.
46. Allers CT, Benjack KJ, Allers NT. Unresolved childhood sexual abuse: Are older adults affected? *Journal of Counseling & Development*. 1992;71(1):14-17.
47. Colarusso CA. The Relentless Past: The Effect of Chronic Sexual Abuse in Childhood on Fifty Years of Adolescent and Adult Development. *Psychoanalytic Study of the Child*. 2009;64:320-350.
48. Gagnon M, Hersen M. Unresolved childhood sexual abuse and older adults: Late-life vulnerabilities. *Journal of Clinical Geropsychology*. 2000;6(3):187-198.
49. Gallo-Silver L, Weiner MO. Survivors of childhood sexual abuse diagnosed with cancer: managing the impact of early trauma on cancer treatment. *J Psychosoc Oncol*. 2006;24(1):107-134.
50. McInnis-Dittrich K. Adapting life-review therapy for elderly female survivors of childhood sexual abuse. *Families in Society*. 1996;77(3):166-173.
51. Osgood NJ, Manetta AA. From the world of practice. Physical and sexual abuse, battering, and substance abuse: three clinical cases of older women. *Journal of Gerontological Social Work*. 2002;38(3):99-113.
52. Sutton L. 'Out of the Silence' When People Can't talk About It. In: Hunt L, Marshall M, Rowlings C, editors. *Past Trauma in Late Life*. London and Bristol, Pennsylvania: Jessica Kingsley Publishers; 1997. p. 155-170.

53. Sandelowski M, Barroso J. Classifying the Findings in Qualitative Studies. *Qualitative Health Research*. 2003;13(7):905-923.
54. Hutchison ED. A Life Course Perspective. *Dimensions of Human Behavior: The Changing Life Course*: Sage Publications; 2008. p. 1-38.
55. Resnick-Cortes C. Seventy Years of Mistrust: Elderly Survivors of Sexual Abuse. *Reflections: Narratives of Professional Helping*. 2006;12(4):75-79.
56. Bergstrom-Walan M. Psycho-Sexual Therapy with Elders. In: Hunt L, Marshall M, Rowlings C, editors. *Past Trauma in Late Life*. London and Bristol, Pennsylvania: Jessica Kingsley Publishers; 1997. p. 31-38.
57. Altschuler J, Katz AD. Sexual secrets of older women: countertransference in clinical practice. *Clinical Gerontologist*. 1996;17(2):51-67.
58. Rosik CH. Geriatric dissociative identity disorder. *Clinical Gerontologist: The Journal of Aging and Mental Health*. 1997;17(3):63-66.
59. Crose RG. Addressing late life developmental issues for women: Body image, sexuality, and intimacy. In: Duffy M, editor. *Handbook of Counseling and Psychotherapy with Older Adults*: Wiley; 1999. p. 57-76.
60. Miesen BML, Jones GMM. Psychic Pain Resurfacing in Dementia From New to Past Trauma? In: Hunt L, Marshall M, Rowlings C, editors. *Past Trauma in Late Life*. London and Bristol, Pennsylvania: Jessica Kingsley; 1997. p. 142-154.
61. Davenport GM. *Working with toxic older adults: a guide to coping with difficult elders*: Springer Publishing Company; 1999.
62. Altschuler J, Katz AD. Keeping your eye on the process: body image, older women, and countertransference. *J Gerontol Soc Work*. 2010 Apr;53(3):200-214.
63. Walter K. That was then: elderly survivors of incest. *J Psychosoc Nurs Ment Health Serv*. 1992 Jan;30(1):14-16.
64. Capasso VA. The theory is the practice: an exemplar. *Clinical nurse specialist CNS*. 1998;12(6):226-229.
65. Hill SA. The man who claimed to be a paedophile. *Journal of Medical Ethics*. 2000;26(2):137-138.
66. Sarkar J. From science to services: Developing a neuroscience-based innovative clinical treatment model to manage severe and repetitive self-harm in a 60-year-old woman with severe personality disorders. *Personality and Mental Health*. 2010;4(4):302-311.

67. McLean LM, Hales S. Childhood trauma, attachment style, and a couple's experience of terminal cancer: Case study. *Palliative and Supportive Care*. 2010;8(2):227-233.
68. Moyer MS. Sibling relationships among older adults. *Generations*. 1992;16(3):55-55.
69. Wadeson H. *Adult Survivors of Childhood Sexual Abuse*. Art Psychotherapy. 2nd ed. Wiley; 2010. p. 99-110.
70. Duenas MT. Impact of long term sexual abuse. *Clinical Gerontologist: The Journal of Aging and Mental Health*. 1986;4(4):47-50.
71. McGregor K, Julich S, Glover M, Gautam J. Health professionals' responses to disclosure of child sexual abuse history: female child sexual abuse survivors' experiences. *Journal of Child Sexual Abuse*. 2010;19(3):239-254.
72. Warne T, McAndrew S. The shackles of abuse: unprepared to work at the edges of reason. *Journal of Psychiatric & Mental Health Nursing*. 2005;12:679-686.
73. Mammen G. *After Abuse*. Book ACER press; 2006