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Childhood trauma, coping, and depressive symptoms among older adults

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ABSTRACT

This study explored the roles of childhood trauma and coping strategies on depressive symptoms among 265 older adults. Hierarchical regression analysis indicated a significant association between a higher level of emotional neglect and increased depressive symptoms. Additionally, a higher level of positive reinterpretation coping was significantly related to decreased depressive symptoms. Conversely, higher levels of venting of emotion coping and denial coping were significantly associated with increased depressive symptoms. The findings of this study offer insights for social workers and practitioners working with older adults, suggesting the use of effective problem-focused coping strategies to minimize depressive symptoms among their clients.

KEYWORDS

Childhood trauma; coping; depressive symptoms; older adults

Introduction

Depressive symptoms are among the most common psychological health problems for older adults. Symptoms of depression have been identified in 20% to 40% older adults, whether they live in the community or in residential care (Hu et al., 2022; Tang et al., 2022). An increase in depression symptoms in older adults may result in medically related health problems or feelings of hopelessness and helplessness (Ansari et al., 2022; Fernandez-Rodrigues et al., 2022; Kang et al., 2014; Vasiliadis et al., 2022; Yoon & Cummings, 2019). Several recent studies have also found that depressive symptoms in older adults often lead to suicidal ideation (Farhat et al., 2022; Vasiliadis et al., 2022; Yoon & Cummings, 2019).

Depression can be a result of medical illness, traumatic events, loss of a loved one, and mass disasters (Bonde et al., 2016; De Leo, 2022). Researchers have also noted that certain childhood experiences are connected to adult depression (Klopack et al., 2022; Wilson-Genderson et al., 2022). Traumatic childhood experiences include exposure to any kind of abuse,

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neglect, or household dysfunction (Dye, 2018). Other types of traumatic childhood events include rape or attempted rape, other sexual contact, threat of violence, witness to a traumatic event, life-threatening illness or accident, robbery or mugging with a weapon, and tragic bereavement (Kim et al., 2021; Watters et al., 2023; Wilson-Genderson et al., 2022). These events are associated with a risk for depression. In addition, Hughes et al. (2017) found that individuals with multiple childhood adversities have a four-times higher risk of mental illness throughout their lifetime.

Survivors of childhood trauma may be more vulnerable to depression when facing stress. However, they may be able to combat depression with coping behaviors (Compas et al., 2017; Gruhn & Compas, 2020). Following internal or external stressful events, individuals may use emotional coping strategies such as heightened avoidance, emotional repression, and emotional dysregulation. They may also engage in cognitive and behavioral actions (Gruhn & Compas, 2020).

Previous researchers have reported that childhood trauma is significantly associated with depression in the later life (Campbell et al., 2016; Easton & Kong, 2017; Kong, 2018; LaNoue et al., 2012; Pirkola et al., 2005; Ramiro et al., 2010; Raposo et al., 2014; Wade et al., 2016). Existing studies have also found that coping strategies play a role in the psychological responses of older adults (Pfluger et al., 2022; Yoon et al., 2020, 2022). Problem-focused coping strategies involve implementing direct actions to address and modify the sources of stress (Compas et al., 2001; Folkman & Lazarus, 1980; Horwitz et al., 2011). In Chen et al. (2018) study, the older adults who were less likely to employ problem-focused coping strategies reported lower positive affect levels in stressful situations. Several researchers have also found that higher depressive symptoms were associated with older adults with emotionally focused coping strategies in stressful conditions (Kong & Moorman, 2015; Yoon et al., 2020, 2022). While some researchers have investigated the connection between childhood trauma and depressive symptoms, the focus has mainly been on the current relationships with abusive parents or partners, on social support, or only on positive coping strategies (Cheong et al., 2017; Kong, 2018; Kong & Martire, 2019; Su et al., 2022; Yoon & Cummings, 2019; Yoon et al., 2020, 2022).

A thorough review of the literature revealed that few studies have investigated the links between childhood trauma, coping skills, and the depressive symptoms in older adults (Kong et al., 2021; Pfluger et al., 2022). Even more significant is the absence of studies examining the impact of specific childhood trauma experiences (e.g., emotional neglect, emotional abuse, physical neglect, physical abuse, and sexual abuse) on depressive symptoms in older adults using a national sample. Additionally, there is a lack of studies that have addressed the types of coping strategies that are the focus of the current study. Specifically, we focus on problem-focused coping strategies (i.e.,

positive reinterpretation coping, active coping, and planning coping), and emotion-focused coping strategies (i.e., venting of emotions coping, behavioral disengagement coping, and denial coping).

Consequently, the primary purpose of the present study is to explore the roles of childhood trauma and problem-focused coping and emotion-focused coping strategies on depressive symptoms among older adults. This study provides unique findings that may help reduce depressive symptoms among older adults by understanding their specific childhood trauma experiences and coping strategies. The findings of the current study provide important insights for social workers and health care providers to enhance appropriate coping skills among older adults, with childhood trauma experiencing depressive symptoms. This exploration was conducted through the analysis of data from a national sample of the Midlife Development in the United States (MIDUS) series.

Literature review

Theoretical framework

The current study employs the Stress Process Model (Pearlin et al., 1981) as the framework to conceptualize the relationships between childhood trauma, coping, and depression among older adults. The Stress Process Model (SPM) posits that, while a stressful life experience can increase psychological and physical health problems, coping resources and responses can mediate the relationship between stress and health issues (Pearlin et al., 1981; Schmitz & Crystal, 2000). In the SPM, coping strategies are often utilized to elucidate the roles in the association between stressors and stress outcomes (Yoon et al., 2020, 2022). The present study focuses on exploring the association between childhood trauma and depression, as well as the links between depression and problem-focused and emotion-focused coping.

Adverse childhood experience and psychological well-being

Recent epidemiological studies have revealed that around 30% of psychological health problems throughout life were due to traumatic childhood experiences (Heerman et al., 2016). Depression has been found to be common among people with experiences of maltreatment or abuse, for both younger (Humphreys et al., 2020; Klein & Kotov, 2016) and older adults (Easton & Kong, 2017; Kong, 2018; Kong & Martire, 2019; Kong & Moorman, 2015; Kong et al., 2021; Yoon et al., 2020, 2022). Children who have experienced physical, emotional, or sexual abuse have a greater risk of developing recurrent and persistent depressive symptoms (Amado et al., 2015; M. Li et al., 2016). Additional previous studies indicate that childhood abuse is associated with

psychopathology in adulthood (Jaye Capretto, 2020; Noll, 2021; Teicher et al., 2022). Cantón-Cortés et al. (2022) found that childhood sexual abuse could place adult females at higher risk for later psychopathology such as depression. In particular, having been abused as a child is linked to an increased risk of emotional distress as an adult (Kim et al., 2021; Taşören, 2022), including depressive disorders (E. T. Li et al., 2020) and mental and personality disorders (Walsh et al., 2017). Additionally, researchers identified that traumatic childhood experiences are strongly related to increased health risk factors in adulthood such as alcoholism, drug abuse, depression, and suicide attempts (Berardelli et al., 2022; Cicchetti & Handley, 2019; Kisely et al., 2020; E. T. Li et al., 2020; Merrick et al., 2017; Thompson et al., 2019).

Coping and psychological well-being

There are traditional ways of coping with trauma which tend to be reactive (Love & Torgerson, 2019), and there are also non-traditional ways which may be contrastingly seen as proactive. Reactive coping as to what happens after a stressful event takes place (Love & Torgerson, 2019; Wang & Hall, 2021). Proactive coping, on the other hand, can take place before stress occurs resulting in more favorable outcomes such as increased optimism, increased life satisfaction, and decreased depression (Wibhowo et al., 2019; Zhang et al., 2022). Coping with stress is associated with psychological defense mechanisms related to an individual's attempts to escape threats (Bakracheva, 2018). People can proactively choose problem solving skills while emotionally reacting in response to the trauma (Bakracheva, 2018).

Folkman and Lazarus (1980) identified two major types of coping strategies: problem-focused coping (e.g., active, planning, positive reinterpretation, etc.) and emotion-focused coping (e.g., denial, behavioral disengagement, etc.) which influence psychological well-being. Generally, people use problem-focused coping when they face controllable situations, but utilize emotion-focused coping when stressful situations are uncontrollable (Kong & Moorman, 2015). Studies found that problem-focused coping is related to decreases in one's psychological distress level, while emotion-focused coping is associated with increased psychological distress (Kong & Moorman, 2015; Yoon et al., 2020, 2022). For example, Yoon et al. (2020, 2022) reported that problem-focused coping was negatively related to depression and suicidal ideation, but emotion-focused coping was positively associated with each. In addition, Yoon et al. (2020, 2022) demonstrated that the greater use of emotion-focused coping was associated with higher depressive symptoms among older adults who experienced spousal/partner physical abuse.

Moreover, Chen et al. (2017) found that there is a need to better promote problem-focused coping strategies among older adults as their findings suggest this population was less likely to implement this type of coping strategy in

comparison to younger populations. Lower use of problem-focused strategies when faced with stressful situations was linked with lower well-being. Problem-focused coping strategies have also been found to improve mental health outcomes among populations such as Chinese women who experienced intimate partner violence (Wong et al., 2016) and individuals with schizophrenia (Chen et al., 2017). However, there is a lack of information on how problem-focused coping strategies play an important role in minimizing depression for older adults in the US population.

Research questions and hypotheses

This study addressed three research questions and tested three hypotheses based on the SPM. The first research question is as follows: what is the role of childhood trauma (emotional neglect, emotional abuse, physical neglect, physical abuse, and sexual abuse) on depressive symptoms among older adults? The first hypothesis is that high levels of childhood trauma will be related to a high level of depressive symptoms. The second research question is as follows: What is the role of problem-focused coping strategies (positive reinterpretation coping, active coping, and planning coping) on depressive symptoms? The second hypothesis is that high levels of problem-focused coping strategies will be associated with low levels of depressive symptoms. The third research question is as follows: What is the role of emotion-focused coping (venting of emotion coping, behavioral disengagement coping, and denial coping) on depressive symptoms? The third hypothesis is that high levels of emotion-focused coping strategies will be related to a high level of depressive symptoms.

Methods

Data and sample

This study utilized the national survey datasets from the Midlife Development in the United States (MIDUS) series, which combined MIDUS II (biomarker project, 2004–2009) and MIDUS II (cognitive project, 2004–2006) data (Agrigoroaei & Lachman, 2011; Ryff et al., 2011, 2013). The reason for choosing these data sources is that they provide comprehensive information to address the research questions of this study. The collaborative and interdisciplinary nature of these projects was essential for understanding the impact of behavioral, psychological, and social factors on mental health, while also considering age-related differences (Ryff et al., 2011, 2013). The surveys included various questions covering topics such as depressive symptoms, health, psychological well-being, childhood trauma, and coping mechanisms for this current study. In addition, the surveys include questions on various

topics such as social responsibility, self-esteem, self-control, social support, discrimination, religiosity, substance abuse, and chronic conditions. A nationally representative random sampling method was employed to select participants from the adult American population aged 25 and older across the United States. A total of 5,164 participants of the MIDUS research were recruited. The survey used mainly computer-assisted personal interviews as well as phone surveys, mail-in surveys, and face-to-face interviews for MIDUS II projects to collect information (French et al., 2022). To enhance the response rate, a payment of $60 was offered per respondent. The response rates were 39.3% for the biomarker project and 52% for the cognitive project (Ryff et al., 2011, 2013). For this current study, a subset of 265 older adults who self-identified as 65 years of age or older were included in the analysis. The sample of this data may not fully represent the entire older adult population, but the sample's age, gender, household income, mental and physical health status are similar with the findings of the National Social Life, Health, and Aging Project's COVID-19 study in 2020–2021 (Zhong et al., 2022) and/or those of the US Census Bureau (Guzman & Kollar, 2023).

Measures and variables

Dependent variable

Depressive Symptoms. To measure the depressive symptoms of older adults, this study used the Center for Epidemiologic Studies Depression Scale (CES-D; Radloff, 1977). Previous studies used the CES-D as a reliable measure for evaluating depressive feelings and behaviors among various populations (Knight et al., 1997; Radloff, 1977; Roberts et al., 1989). Haringsma et al. (2004) indicated that the criterion validity of the CES-D for the DSM-IV Major Depressive Disorder scale and Clinically Relevant Depression scale was satisfactory in the sample of older adults. The CES-D consists of 20 items with a 4-point response format, ranging from 1 (rarely or none of the time, less than 1 day) to 4 (most or all of the time, 5–7 days). Example questions from the scale include "I did not feel like eating; my appetite was poor," "I felt depressed," and "I had trouble keeping my mind on what I was doing." Radloff (1977) reported high reliability scores for the scale, with Cronbach's alpha .90 in clinical samples and .84–.85 in community samples. In the current study, the Cronbach's alpha was .75.

Independent variables

Childhood Trauma. The Childhood Trauma Questionnaire (CTQ) is used to measure childhood abuse and neglect trauma of older adults (Bernstein & Fink, 1998). Previous studies indicated that the CTQ is valid for clinicians and therapists to measure childhood abuse and neglects (Bernstein & Fink, 1998; Bernstein et al., 2003; Fink et al., 1995). This study used the five subdomains of

the CTQ; emotional neglect (5 items), emotional abuse (5 items), physical neglect (5 items), physical abuse (5 items), and sexual abuse (5 items) with a 5-point format ranging from 1 (never true) to 5 (very often). Questions in each subdomain include: "I felt loved," "People in my family said hurtful or insulting things to me," "I didn't have enough to eat," "I was punished with a belt, a board, a cord, or some other hard object," and "Someone tried to make me do sexual things or watch sexual things." Bernstein and Fink (1998) reported internal consistency scores to exceed .66. In this current study, Cronbach's alphas were from .63 to .91.

Problem- and Emotion-Focused Coping. This study uses a modified COPE inventory to measure both problem- and emotion-focused coping (Carver et al., 1989; Ryff et al., 2011). The scale had been shown to be a valid measure of problem and emotional coping in various populations (Carver & Scheier, 1993; Carver et al., 1992). Problem-focused coping includes three subdomains; positive reinterpretation coping (4 items), active coping (4 items), and planning coping (4 items) with a four-point format, ranging from 1 (*I usually don't do this at all*) to 4 (*I usually do this a lot)*. Example items in each subdomain include "I try to grow as a person as a result of the experience," "I concentrate my efforts on doing something about it," and "I make a plan of action." Emotion-focused coping composes three subdomains; venting of emotions coping (4 items), behavioral disengagement coping (4 items), and denial coping (4 items) with a four-point format, ranging from 1 (*I usually don't do this at all*) to 4 (*I usually do this a lot)*. Items in each subdomain involve: "I get upset and let my emotions out," "I admit to myself that I cannot deal with it and quit trying," and "I refuse to believe that it happened." Carver et al. (1989) demonstrated that reliability scores exceeded values of .62 for each subscale of the problem, focused coping and .71 for the emotion-focused coping. In this current study, Cronbach's alphas were from .69 to .81.

Data analysis

This study used descriptive statistics and a correlation matrix to understand demographic characteristics and bivariate correlations among the main variables of this study. In addition, the study used a hierarchical multivariate regression to test the three hypotheses, focusing on the roles of childhood trauma and problem focused and emotion focused coping on the dependent variable, depressive symptoms (Mertler et al., 2021). This multivariate approach also specified the explained variance in the depressive symptoms accounted for by three different steps in our models (George & Mallery, 2019). All continuous variables were normally distributed as the skewness scores were between −2 and 2 (Byrne, 2010; Hair et al., 2010). The variance inflation factor scores for all independent variables were lower than 3.44, indicating no observation of multicollinearity problems in this study (Mertler et al., 2021).

For all data analysis, IBM Statistical Package for the Social Sciences (SPSS) software (version 26) was used.

Results

Demographic characteristics among older adults

Table 1 presents the demographic characteristics of 265 older adults. Participants ranged in age from 65 to 84, with a mean age of 71.7 years; around 56% were female, and 67.6% were married. Most participants (95.1%) were Caucasians and 2% were African Americans. Approximately, 46.2% of the participants made less than $40,000 annually. Over 89% of the participants answered that they had good, very good, or excellent health. In addition, 19% were employed.

Correlations, means, and standard deviations of main scale variables

Table 2 presents the correlations among variables and ranges, means, and standard deviations of depressive symptoms, childhood trauma variables, and coping variables. Correlation results revealed that depressive symptoms were positively significantly correlated with emotional abuse, emotional neglect, and physical neglect. Also, depressive symptoms were negatively significantly related to positive reinterpretation, active, and planning coping variables, but positively significantly correlated with venting of emotions, denial, and behavioral disengagement coping variables. Mean score of 7.21 for depressive symptoms in this study was slightly lower than 8.33 of community residing older adults (Lewinsohn et al., 1997). Around 9.5% of the participants had severe or mild depressive symptoms.

Table 1. Demographic characteristics among participants (% or mean, $N = 265$).

Age	Range: 65 to 84 years	Mean 71.7
Gender	Female	55.8
	Male	44.2
Marital status	Married	67.6
	Widowed	17.2
	Divorced	11.9
	Never married	2.5
	Others (separated, etc.)	0.8
Ethnicity	Caucasian	95.1
	African American	2.0
	Other	2.9
Annual household income	$0-$40,000	46.2
	$40,001-$80,000	30.9
	Over $80,001	22.9
Perceived health	Poor or fair	10.7
	Good, very good, or excellent	89.3
Being employed	Yes	19.0
	No	81.0

Table 2. Correlations, ranges, means, and SDs[1] among main-scale variables ($N = 265$).

	Depressive symptoms	Ranges	Means	*SDs*[1]
Depressive symptoms		0-29	7.21	2.77
Childhood trauma				
Emotional abuse	.303***	5-21	6.72	2.74
Physical abuse	.108	5-13	6.11	1.76
Sexual abuse	.036	5-23	6.10	3.05
Emotional neglect	.363***	5-25	8.81	4.03
Physical neglect	.263***	5-19	6.77	2.52
Coping strategies				
Positive reinterpretation coping	−.350***	5-16	12.45	2.38
Active coping	−.292***	6-16	12.67	2.14
Planning coping	−.232***	6-16	13.09	2.20
Venting of emotion coping	.278***	4-16	8.70	2.59
Denial coping	.336***	4-16	6.15	2.09
Behavioral disengagement coping	.213***	4-13	7.26	2.25

Notes. *$p \leq .05$, **$p \leq .01$, ***$p \leq .001$; [1] Standard deviations.

The role of childhood trauma and coping on depressive symptoms

The hierarchical multivariate regression results in Table 3 present the roles of childhood trauma and coping variables on the depressive symptoms of older adults. Findings indicated that demographic variables in step one explained 11.6% of the variances (R^2) in the depressive symptoms of older adults. In step two, demographics and childhood trauma accounted for 23.9% of the variances (R^2) which was an increase of 12.3% from step one. In the final step,

Table 3. Coefficients of hierarchical regression for the role of childhood trauma and coping In depressive symptoms ($N = 265$).

	Depressive symptoms		
	B^1 (SE^2)		
Demographics	Step 1	Step 2	Step 3
Age	.017 (.075)	.091 (.072)	.152 (.068)
Female	.129 (.778)	.276 (.769)	.562 (.733)
Married	−.574 (.837)	.120 (.794)	.321 (.750)
Annual household income	−.210 (.231)	−.142 (.217)	.195 (.205)
Perceived health	−1.979 (.406)***	−1.446 (.394)***	−.898 (.378)*
Being employed	−.227 (.961)	−.155 (.911)	−.135 (.837)
Childhood trauma			
Emotional abuse		.329 (.161)*	.264 (.149)
Physical abuse		−.372 (.224)	−.334 (.208)
Sexual abuse		−.115 (.117)	−.083 (.107)
Emotional neglect		.426 (.124)***	.345 (.117)**
Physical neglect		.079 (.175)	.125 (.164)
Coping strategies			
Positive reinterpretation coping			−.572 (.179)**
Active coping			−.438 (.268)
Planning coping			.460 (.264)
Venting of emotion coping			.387 (.142)**
Denial coping			.641 (.187)***
Behavioral disengagement coping			−.031 (.170)
F tests (*d.f.* − 6, 11, & 17)	4.922***	6.311***	7.856***
R^2	.116	.239	.383
Adjusted R^2	.092	.201	.334

Notes. *$p \leq .05$, **$p \leq .01$, ***$p \leq .001$; [1] Unstandardized Beta coefficients, [2] Standard errors.

demographics, childhood trauma, and coping explained 38.3% of the variances (R^2) which was an increase of 14.4% from step two.

As this study hypothesized, results indicated that some childhood trauma and coping variables were significantly associated with depressive symptoms among older adults. A higher level of emotional neglect was significantly associated with a higher level of depressive symptoms among older adults ($\beta = .345$, $p \leq .01$). In terms of coping, a higher level of positive reinterpretation coping was significantly related to a lower level of depressive symptoms ($\beta = -.572$, $p \leq .01$). A higher level of venting of emotion coping was significantly related to a higher level of depressive symptoms ($\beta = .387$, $p \leq .01$). A higher level of denial coping was significantly related to a higher level of depressive symptoms ($\beta = .641$, $p \leq .001$). In addition, higher perceived health was significantly associated with a lower level of depressive symptoms ($\beta = -.898$, $p \leq .05$).

Discussion and implications

The current study's main purpose was to explore the roles of childhood trauma and coping strategies on depressive symptoms among older adults from a nationally representative sample. The key findings of this study provide insights for future coping strategies to minimize depressive symptoms among older adults. The first hypothesis was that high levels of childhood trauma (emotional neglect, emotional abuse, physical neglect, physical abuse, and sexual abuse) will be related to high levels of depressive symptoms. This hypothesis was partially supported as we found that only a higher level of emotional neglect was significantly associated with a higher level of depressive symptoms among older adults. This finding is consistent with previous studies showing that childhood neglect or abuse is significantly associated with psychological well-being among older adults (Jaye Capretto, 2020; Noll, 2021; Teicher et al., 2022). However, it is a unique finding in that this current study found a significant relationship between emotional neglect in childhood and depressive symptoms among older adults. Emotional neglect in childhood can have lasting effects on individuals throughout their lives, including into older adulthood. Older adults who experienced emotional neglect in childhood may continue to struggle with emotional regulation and expression. They may find it challenging to manage and cope with negative emotions which lead to an increased vulnerability to depressive symptoms (Raposo et al., 2014; Van Assche et al., 2020). In addition, emotional neglect can contribute to long-lasting self-esteem issues that persist into older adulthood. Older adults who experienced emotional neglect may harbor feelings of unworthiness, low self-esteem, and negative self-beliefs, which can contribute to depressive symptoms (Sachs-Ericsson et al., 2010). Also, emotional neglect can disrupt the formation of secure attachments and healthy relationships which may impact older adults' social connections and support systems. Difficulties in forming and

maintaining relationships can lead to feelings of loneliness, social isolation, and a lack of social support; all of which are associated with increased risk of depressive symptoms (Wielaard et al., 2018). Social workers and healthcare providers can play a crucial role in supporting older adults with depression who have been impacted by emotional neglect in childhood. First, social workers and healthcare providers can conduct thorough assessments to identify depression symptoms and explore the impact of emotional neglect on the individual's mental health (Reuben et al., 2016). Second, social workers and healthcare providers can offer empathetic listening, validation, and emotional support to help older adults to process and address the emotional wounds from their childhood. Finally, social workers and healthcare providers can offer various therapeutic interventions tailored to the specific needs of older adults (Fitzgerald & Gallus, 2020). These may include individual therapy, group therapy, cognitive-behavioral therapy, or other evidence-based approaches (Bollmann et al., 2020; Gould et al., 2012). Therapy can help older adults develop coping strategies, improve emotional regulation skills, challenge negative self-belief, and address unresolved issues related to emotional neglect.

The second hypothesis that high levels of problem-focused coping strategies will be associated with a lower level of depressive symptoms was also partially supported in that a higher level of positive reinterpretation coping was significantly related to a lower level of depressive symptoms. The finding of this study is consistent with some previous studies indicating the key role of coping on psychological well-being among older adults (Chen et al., 2017; Yoon et al., 2022), but this study has a unique contribution indicating a direct relationship between positive reinterpretation of coping and depressive symptoms among older adults. Positive reinterpretation coping involves reframing and reinterpreting negative experiences or events in a more positive or meaningful light. It can play a beneficial role in reducing depressive symptoms among older adults (Roohafza et al., 2014). Social workers and healthcare providers can utilize positive reinterpretation coping strategies to support older adults with depression. First, social workers and healthcare providers can educate older adults about the concept of positive reinterpretation coping, explaining its benefits and providing examples. This helps older adults understand how reframing negative experiences can impact their emotional well-being and contribute to reducing depressive symptoms (Roohafza et al., 2014). Second, social workers and health care providers may use narrative therapy techniques which involve helping older adults construct and reconstruct their life stories in a more positive and empowering manner. By highlighting strengths, resilience, and positive experiences, older adults can develop a new narrative that emphasizes personal growth and potential. This can lead to a more positive outlook and reduced depressive symptoms (Reynolds et al., 2020). Finally, social workers and health care providers may facilitate group therapy or

support groups for older adults with depression. These settings provide opportunities for individuals to share their experiences and learn from one another. Through group discussions and interactions, older adults can witness different perspectives and gain insights into positive reinterpretation coping strategies from their peers (DeAndrea, 2015).

The third hypothesis was that high levels of emotion-focused coping strategies will be related to a high level of depressive symptoms. This was partially supported as this current study revealed that higher levels of venting of emotional coping and denial coping were significantly positively related to higher levels of depressive symptoms. This finding is consistent with some previous studies indicating that emotion focused coping is particularly important to psychological well-being among older adults (Yoon et al., 2020, 2022), but the current study's finding is unique in that it revealed the significantly negative role of venting of emotion coping and denial coping with depressive symptoms among older adults. For example, excessive venting without constructive strategies for coping can lead to rumination. Older adults may dwell on negative thoughts and emotions without actively seeking resolution or reframing their experiences. This can reinforce negative thinking patterns and exacerbate depressive symptoms (Ahn & Kim, 2015). Venting alone may not equip older adults with the necessary skills to effectively manage their depressive symptoms. Without addressing underlying issues or developing constructive coping strategies, they may struggle to make positive changes in their lives or experience long-term relief from depression (Raut et al., 2014). Also, denial coping often involves suppressing or ignoring negative emotions, including those related to depression. By avoiding or denying these emotions, older adults may miss out on opportunities for emotional processing, validation, and seeking appropriate support (Bjørkløf et al., 2013). By providing education about healthy coping strategies, including the limitations of excessive venting or denial coping, social workers, and healthcare providers can help older adults understand the potential drawbacks and explore alternative approaches (Visser et al., 2014). Psychoeducation helps build awareness and encourages the development of more constructive coping mechanisms. Social workers and healthcare providers can guide older adults in identifying specific goals and implementing problem-solving techniques to address the underlying issues contributing to their depressive symptoms. This approach helps shift the focus from venting or denial to taking active steps toward resolving problems and improving well-being (D'Zurilla & Nezu, 2010).

In addition, this study found that perceived health is a significant factor in decreasing depressive symptoms. Chronic health conditions, such as heart disease, diabetes, arthritis, or neurological disorders, can increase the risk of depression among older adults. Dealing with the challenges, limitations, and pain associated with these conditions can contribute to feelings of sadness, hopelessness, and a decline in overall well-being. Social workers and

healthcare providers can educate older adults about the importance of adopting healthy lifestyle habits. This may include providing guidance on maintaining a balanced diet, engaging in regular physical activity appropriate for their abilities, getting sufficient sleep, and avoiding harmful habits like smoking or excessive alcohol consumption. Education on the benefits of healthy lifestyle choices can motivate older adults to make positive changes to improve their overall health and well-being.

Limitations and future research

The findings presented in this study make a valuable contribution to the existing literature on childhood trauma and coping strategies in relation to the depressive symptoms of older adults. However, it is important to acknowledge several limitations associated with this study. First, the main interview techniques used in the MIDUS survey were computer-assisted, which has benefits like high reliability, validity, and confidentiality, as well as lowered literacy hurdles. The difficulty of including open-ended questions to acquire comprehensive personal information is one drawback of this strategy. During face-to-face interviews, interviewers could ask more open-ended questions to participants to elicit more in-depth thoughts in order to address this issue in the future studies. Second, this study did not establish causality between childhood trauma, coping strategies, and depressive symptoms among older adults. It is challenging to determine whether coping strategies preceded the development of depressive symptoms. However, the study did reveal an association between these variables. To further elucidate the causal relationship, future research could employ experimental designs to investigate how coping strategies influence the psychological health problems of older adults. This study expected that other factors of childhood trauma such as emotional abuse, physical neglect, physical abuse, and sexual abuse will be associated with depressive symptoms, but did not find significant associations among them. A future study can investigate this to test if the findings are congruent or not.

In addition, it is crucial to acknowledge the potential for measurement errors in this study. Although the scales utilized in the research exhibit acceptable internal consistency, they may not fully capture the complex and nuanced perceptions of childhood trauma, coping strategies, and depressive symptoms. It is important to recognize that different ethnic groups may have diverse cultural norms and expressions related to these variables which may not be adequately captured by the scales used. Conducting a comparative study among different ethnic groups would provide valuable insights into understanding the variations in these variables and their impact on depressive symptoms.

Finally, the Midlife Development in the United States (MIDUS) data used in the analysis were collected about two decades ago. The sample only consisted of 265 adults aged 65 and older, with a majority in good health (89%) and Caucasians (about 95%). Thus, the study sample may not be fully representative of the older adult population, and statistically significant findings might be attributed to chance. However, compared to the National Social Life, Health, and Aging Project's COVID-19 study in 2020–2021 (Zhong et al., 2022) findings, many older adults (60+) had good, very good, or excellent mental health (87.8%) and physical health (83.2%) reflecting 2445 participants. This is congruent to the present study's findings. In addition, the US Census Bureau (Guzman & Kollar, 2023) indicated that the median income in 2022 for householders aged 65 and over was $50,290. Our current study's mean and median household incomes are $51,677 and $43,125 which is very similar to the U.S Census Bureau's results. These support that the results of the Midlife Development in the United States (MIDUS) series have more representation than the results of unrandomized small sample studies. Nonetheless, future studies need to analyze more representative and recent data.

Conclusion

This study found that an emotional neglect experience in childhood was a significant factor in increasing depressive symptoms among older adults. In terms of coping, positive reinterpretation coping was a significant factor in decreasing depressive symptoms. However, venting of emotion coping and denial coping were significant factors in increasing depressive symptoms. This study's findings provide important insights for social workers and health care providers to understand the roles of childhood trauma and different coping strategies on depressive symptoms among older adults. Social workers and healthcare providers can play a significant role by assessing the mental health issues of older adults impacted by emotional neglect in childhood and offering emotional support and various therapeutic interventions to minimizing the depressive symptoms of older adults. Also, social workers and mental health service providers need to educate their clients in positive reinterpretation coping strategies, healthy coping strategies, or problem-solving techniques to address the depressive symptoms of older adults.

Disclosure statement

No potential conflict of interest was reported by the author(s).

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