Trauma and PTSD Symptoms: exploring the experiences of autistic and non-autistic adults in midlife and old age

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Abstract

Objectives

Autistic children and young adults have been found to experience high rates of traumatic life experiences and symptoms of PTSD when compared to their non-autistic peers. However, despite the lifelong nature of autism and evidence that trauma and PTSD can impact people of all ages, these issues have yet to be studied in middle-aged and older autistic adults.

Methods

This pre-registered study used data from the second wave of the AgeWellAutism study (autistic n = 469, non-autistic n = 183; aged 40 to 90, mean = ~ 60 years; ~55% female). Participants completed widely used and standardised measures of childhood and adulthood trauma, and symptoms of PTSD.

Results

The autistic group, and particularly autistic women and people in middle-age, reported significantly higher rates of childhood and adulthood trauma, including emotional and physical abuse/neglect and sexual abuse [ORs = 2 ~ 6]. The autistic group reported more PTSD symptoms than the non-autistic comparison group. PTSD symptoms showed stronger associations with childhood and adulthood trauma in the autistic vs. non-autistic group. Autism group remained a significant predictor of PTSD symptom score variance when controlling for differences in reported trauma.

Conclusions

These findings suggest that autistic adults are at higher risk for trauma and developing symptoms of PTSD than their non-autistic peers. Longitudinal studies are required to investigate how trauma risk and impact and subsequent PTSD symptoms change with age in middle-aged and older autistic adults. This study underscores the need to develop evidence-based interventions to prevent trauma throughout the lifespan and address PTSD symptoms in autistic populations as they age.

INTRODUCTION

Autism is a lifelong set of neurodevelopmental conditions characterised by differences in social communication and the presence of restricted, repetitive patterns of behaviours, interests, and activities (American Psychiatric Association, 2013). Global and UK prevalence estimates suggest that approximately 1% of the population are autistic (Santomauro et al., 2024; O'Nions et al., 2023), which represents upwards of 680,000 people in the UK, with approximately half being over the age of 40 (Office for National Statistics, 2022). However, despite this large and growing population of autistic people in midlife and old age, autism research to date has primarily focused on autistic children and young people, with only 0.4% of indexed autism research since 1980 focusing

on old age (Mason et al., 2022). Thus, we know little about the needs and experiences of autistic people as they age (Stewart and Happé, 2025).

A topic that has been raised as a priority research area in consultation with the autistic community is the experience and impact of traumatic life events on autistic people's mental health (Benevides et al., 2020). A growing body of evidence suggests a link between autism with higher rates of traumatic life experiences and symptoms of post-traumatic stress disorder (PTSD) in children and young people (Quinton et al., 2025). However, exploration of these experiences has been widely neglected in autistic populations in midlife and old age (see Quinton et al., 2024 for a recent review). Existing research suggests that autistic youth (i.e., those under 18 years) are twice as likely to experience bullying and parental neglect compared to non-autistic youth (Hartley et al., 2023). While a paucity of research has focused on adulthood experiences (Hernández-González et al., 2023; Trundle et al., 2023), a small number of studies suggest that autistic (and high autistic trait) adults are also at risk of experiencing higher rates of physical, emotional, and sexual trauma compared to their non-autistic peers (Andrzejewski et al., 2023; Stewart et al., 2022). These findings highlight a particular risk of sexual victimization for autistic women (Dike et al., 2023), and identify partners or ex-partners as the most likely perpetrators of autistic adults' trauma (Andrzejewski et al., 2023; Gibbs et al., 2023; Pearson et al., 2023).

Furthermore, experiences of interpersonal trauma have been found to be linked to adverse psychological outcomes in autistic people, including high rates of PTSD (Haruvi-Lamdan et al., 2019; Rumball et al., 2021). These findings suggest that up to 45% of autistic adults report levels of PTSD symptoms that exceed clinical cut-offs (Quinton et al., 2024). However, it remains untested if differences in PTSD symptom severity in autistic people are due to increased vulnerability to developing PTSD or higher levels of trauma experienced by autistic populations.

To the authors' knowledge, only one study to date has explored the experience of trauma and PTSD symptoms in midlife and old age in relation to the autism spectrum. Using cross-sectional data from a large general population ageing cohort, Stewart et al., (2022) found that middle-aged and older adults with high autistic traits (n = 251; 1.2% of total sample) reported significantly higher rates of trauma in childhood and adulthood (compared to an age/gender-matched group selected for low autistic traits; n = 9,179). These rates represented a two to seven-fold risk increase in emotional abuse and neglect, physical abuse and neglect, and sexual abuse. Additionally, Stewart et al., (2022) found that the high autistic traits group reported more symptoms and above cut-off rates of PTSD (including when accounting for symptoms of depression and anxiety). Finally, exposure to trauma had a compounded effect in the high autistic traits group, resulting in significantly higher mental health problem scores. While these findings have yet to be replicated in a middle-aged and older adult diagnosed autism sample, similar findings have been documented in autistic samples in younger adulthood (Haruvi-Lamdan et al., 2019; Rumball et al., 2021)

To address this gap in our understanding of trauma and PTSD in autistic midlife and old age, the current study seeks to replicate and expand on the findings of Stewart et al., (2022) using a sample of middle-aged and older autistic and non-autistic adults. This study will investigate prevalence of traumatic experiences in childhood and adulthood and current symptoms of PTSD. It is hypothesized that autistic adults in midlife and old age will (1) report a higher prevalence of traumatic childhood and adulthood experiences than non-autistic people, (2) report elevated and above clinical cut-off symptoms of PTSD, and that (3) exposure to severe trauma in childhood/adulthood will have a stronger association with elevated symptoms of PTSD when compared to a

matched non-autistic adult group. Across each of these hypotheses, gender differences (men vs. women) and age-effects (midlife, 40–64 years vs. old age, 65 + years) will also be examined to increase our understanding of sub-group differences within mid-to-later life.

METHODS

Study Design

This study uses cross-sectional data from the second wave of the AgeWellAutism study, conducted in September 2023 (Ethics: UCL-REC-25855/001). The AgeWellAutism study is an online survey exploring ageing on the autism spectrum and was shaped by a series of patient and public involvement (PPI) interviews with 12 middle-aged and older autistic adults.

Inclusion criteria included: 1) being able to read/write in English, 2) having access to an internet-enabled device, and 3) being aged 40 years and over. The study had no specific exclusion criteria. Participants were recruited through multiple channels, e.g., prior participation in the first wave of the study, through social media (e.g., Reddit), and through adverts circulated by the Cambridge Autism Research Database, Autistica's Research Network and the Matthews Hub. These adverts described the study as exploring factors that influence autistic and non-autistic adults' quality of life in midlife and old age and did not specifically reference trauma or PTSD symptoms.

Participants accessed the survey online via Qualtrics. Before beginning, participants were required to review an information page that detailed the study's aims and objectives prior to providing informed consent. The participants were then presented with demographic information questions, followed by a series of standardised questionnaires examining a variety of topics, including experiences of trauma and current mental health symptoms. Upon survey completion, participants were presented with a debriefing information sheet. A draw for one of twenty £20 gift vouchers was offered as an incentive.

Participants

In total, 738 completed responses were recorded, of which 86 were excluded due to suspected automated survey bot activity (e.g. completion times under 10 minutes and/or providing irregular answers to the open-text questions). Due to the gender difference focus of this study, 23 gender diverse participants were omitted due to lacking statistical power to examine gender group differences. This resulted in a final total of 629 participants aged 40–90 years included in our analysis.

The autistic group (n = 446) comprised 385 participants with a formal autism diagnosis and 61 who self-identified as autistic, while the remaining 183 participants formed the non-autistic group. Most autistic participants were diagnosed in adulthood (mean years since diagnosis/identification = 11.7), with only 14 (3.1%) diagnosed in childhood. The autistic and non-autistic groups were broadly comparable in gender and age distribution. Among the autistic group, 247 (55.4%) were women and 301 (67%) were in midlife (ages 60–64), compared with 113 (61.7%) women and 111 (60%) in midlife in the non-autistic group.

Some statistically significant group differences were found in the demographic characteristics of the autistic and non-autistic groups. The mean age of the autistic group was younger than the non-autistic group (59.1 years vs. 61.6 years, respectively). The autistic group were also more likely to be non-heterosexual, white ethnicities, be more likely to rent their home, have a university level qualification, be unemployed, and be single. See Table 1 for demographic characteristics of the autistic and non-autistic groups.

Table 1
Demographic Characteristics of the Autistic and Non-autistic Groups.

		Autistic adults (*n* = 446)		Non-autistic adults (*n* = 183)		Group Difference	Effect Size
Age (years)	*M (SD)*	59.11 (11.48)		61.63 (11.47)		t (627) = -2.5, p = 013*	d = −0.22
	[95% CI]	[58.00–60.25]		[60.08–63.36]			[-0.39 to -0.05]
	Range	40–86		41–90			
Gender	*Women : Men*	247 (55.4%)	199 (44.6%)	113 (61.7%)	70 (38.3%)	χ2 = 2.15, p = .143	v = .06
Sexuality	*Heterosexual : Other*	316 (70.9%)	130 (29.1%)	161 (88.0%)	22 (12.0%)	χ2 = 20.77, p < .001***	v = .18
Ethnicity	*White : Other*	419 (93.9%)	27 (6.1%)	158 (86.3%)	25 (13.7%)	χ2 = 9.90, p = 0.002**	v = .16
Country	*UK : Rest of the world*	394 (88.3%)	52 (11.7%)	149 (81.4%)	34 (18.6%)	χ2 = 5.26, p = .022*	v = .09
Home ownership	*Own home : Other*	278 (62.3%)	168 (37.7%)	158 (86.3%)	22 (13.7%)	χ2 = 35.16, p < .001***	v = .24
Education history	*No formal qualifications*	19 (4.30%)		5 (2.7%)		χ2 = 18.96, p = .002**	v = .17
	Secondary education	137 (30.7%)		53 (29.0%)			
	Vocational qualification	40 (9.0%)[a]		35 (19.1%)[a]			
	Undergraduate	86 (19.3%)		32 (17.5%)			
	Postgraduate	124 (27.8%)[a]		34 (18.6%)[a]			
	Other	40 (9.0%)		24 (13.1%)			
Employment status	*Employed*	252 (54.8%)[a]		116 (63.4%)[a]		χ2 = 29.22, *p* < .001***	v = .22
	Student/volunteer	55 (12.6%)[a]		6 (3.3%)[a]			

		Autistic adults (n = 446)		Non-autistic adults (n = 183)	Group Difference	Effect Size
	Unemployed	59 (13.5%)[a]		8 (4.4%)[a]		
	Retired	136 (31.1%)		59 (32.2%)		
Relationship status	*Married / relationship*	221 (49.7%)[a]		127 (69.4%)[a]	$\chi 2$ = 29.83, p < .001***	v = .22
	Single	214 (48.1%)[a]		46 (25.1%)[a]		
	Widowed	10 (2.2%)[a]		10 (5.5%)[a]		
ASD diagnosis	*Diagnosed: self-identified*	385 (86.3%)	61 (13.7%)	-	-	-
Years since diagnosis/identity	*M (SD)*	11.82 (10.47)				
	Range	0–56				

Note. Effect size calculated using Cohen's *d* or Cramer's *v*. [a] A significant difference in adjusted residual values between cells. * p < .05, ** p < .01, *** p < .001.

Table 1 **HERE**

Materials

Demographic Information. Participants provided detailed demographic information including age, gender, ethnicity, sexuality, country of residence, education level, employment status, relationship status, and living situation.

Childhood and Adulthood Trauma. Childhood and adulthood trauma were assessed using the five-item Childhood Trauma Screener (CTS-5; Grabe et al., 2012) and the five-item Adult Trauma Screener (ATS-5; Khalifeh et al., 2015), respectively. Both use a 5-point scale (0 = 'never true' to 4 = 'very often true') to assess experiences of sexual abuse, and emotional or physical abuse or neglect. Total scores range from 0 to 20, with an item cut-off of ≥ 2 ('sometimes true') indicating the presence of a trauma type (Stewart et al., 2022). The CTS-5 has shown acceptable internal consistency in the general population (Cronbach's α = .68; Witt et al., 2022), though the psychometric properties of both measures have not been examined in autistic populations. In the current sample, internal consistency was acceptable for the CTS-5 (autistic group α = .73; non-autistic group α = .57) and acceptable to poor for the ATS-5 (autistic group α = .60; non-autistic group α = .38). These lower coefficients

likely reflect the brief nature of the measures and the varied types of trauma assessed, as individuals may have experienced some forms of abuse but not others.

PTSD Symptoms. Symptoms of post-traumatic stress disorder (PTSD) were measured using the six-item Post Traumatic Stress Disorder Checklist (PCL-6; Lang & Stein, 2005).The PCL-6 uses a 5-point scale (ranging from 1 = "not at all", to 5 = "extremely"), to assess how often an individual has felt bothered by a range of DSM-5 based symptoms for PTSD over the past month (e.g. "had recurring, troubling, and unwanted memories of the stressful experience"). Scores are summed for a total score (range 6–30), with higher scores indicating a greater severity of PTSD symptoms. Using the conventional cut-off score of ≥ 14, the PCL-6 has 80% sensitivity and 76% specificity for PTSD and has demonstrated good internal consistency in non-autistic adult populations (Han et al., 2016). In the current sample, the internal consistency of the PCL-6 was acceptable in the autistic group (Cronbach's α = .79) and good in the non-autistic group (Cronbach's α = .82).

Covariates – Depression and Anxiety. Symptoms of depression and anxiety were assessed using the nine-item Patient Health Questionnaire (PHQ-9; Kroenke et al., 2001) and the seven-item Generalised Anxiety Disorder questionnaire (GAD-7; Spitzer et al., 2006), respectively. Both measures use 4-point response scales to assess how often individuals have been bothered by symptoms over the past two weeks (0 = 'not at all' to 3 = 'nearly all of the time'). Scores are summed to produce total scores (PHQ-9 range 0–27; GAD-7 range 0–21), with higher scores indicating greater symptom severity. Using conventional cut-off scores of ≥ 10, the PHQ-9 shows 88% sensitivity and 88% specificity for major depressive disorder, and the GAD-7 shows 89% sensitivity and 82% specificity for generalised anxiety disorder. Both measures have demonstrated good psychometric validity in non-autistic older adults (Moreno-Agostino et al., 2022; Vasiliadis et al., 2015) and in autistic populations (PHQ-9: Cronbach's α = .91, Arnold et al., 2020; GAD-7: Robeson et al., 2024). In the current sample, internal consistency was good for both measures in the autistic group (PHQ-9 α = .86; GAD-7 α = .86) and acceptable to good in the non-autistic group (PHQ-9 α = .83; GAD-7 α = .79).

Data Analysis

All statistical analyses were conducted using SPSS (version 29.0; IBM Corp, 2022). Analyses for hypotheses 1–3 were pre-registered (https://osf.io/2vnhy); analyses of age group differences and the regression model were added post-hoc. Exploration of these age group differences were added due to the lack of research that specifically focuses on autistic people in old age; as health services often have specialist services for people aged over 65, we opted to stratify our sample into a midlife (ages 40–64) and old age (aged 65+) subgroups.

Group differences (autistic vs. non-autistic) in demographic variables were examined using t-tests (continuous) and chi-square (χ^2) tests (categorical); adjusted residuals were used to interpret categorical results. Additional χ^2 tests assessed autism, gender (men vs. women), and age group (midlife vs. old age) differences in the proportion of participants exceeding cut-off scores in childhood trauma, adulthood trauma and PTSD symptoms. 2x2 ANOVAs tested main effects and interactions between autism group and gender, and autism group and age group, on trauma exposure and symptoms. ANCOVAs examined these effects while controlling for depression and anxiety (due to their influence on self-reporting). Pearson correlations assessed associations between trauma and PTSD symptoms within and between groups; Fisher's r-to-z transformations tested for group differences in correlations. A post-hoc multiple regression tested the effect of autism group on PTSD symptoms, controlling for age, gender, and trauma exposure.

Multiple comparisons were corrected using the False Discovery Rate (FDR) method (Benjamini & Hochberg, 1995), with an initial α = .05. All significant analyses survived the adjusted FDR α-threshold.

RESULTS

Overall trauma exposure

The autistic group reported significantly higher overall trauma scores in childhood and adulthood than individuals in the non-autistic group (including when accounting for symptoms of depression and anxiety). See Table 2.

Table 2
Group differences in self-report measures in the autistic and non-autistic group.

	Autistic (*n* = 446)	Non-autistic (*n* = 183)	Group Difference	Effect Size
Childhood trauma *(max score = 20)*	5.04 (3.92) [4.67–5.40]	2.74 (2.51) [2.37–3.11]	$F(1,627) = 53.71$, $p < .001$***	*d = .64 [.47 – .82]*
Adulthood trauma *(max score = 20)*	4.99 (3.55) [4.66–5.32]	2.81 (2.39) [2.46–3.16]	$F(1,627) = 57.91$, $p < .001$***	*d = .67 [.49 – .84]*
PTSD symptoms *(max score = 30)*	11.37 (5.45) [10.86–11.88]	5.81 (5.04) [5.07–6.54]	$F(1,627) = 141.07$, $p < .001$***	*d = 1.06 [.86–1.22]*
N (%) scoring above cut-off (≥ 14)	147 (33.3%)	17 (9.3%)	$\chi^2 = 37.71$, $p < .001$***	*v = .24*
Anxiety *(max score = 21)*	9.12 (5.23) [8.63–9.61]	4.78 (3.92) [4.21–5.35]	$F(1,627) = 101.83$, $p < .001$***	*d = .89 [.71–1.06]*
n (%) scoring above cut-off (≥ 10)	191 (42.8%)	22 (12.0%)	$\chi^2 = 54.97$, $p < .001$***	*v = .29*
Depression *(max score = 27))*	11.67 (6.23) [11.09–12.25]	6.46 (5.18) [5.71–7.22]	$F(1\ 627) = 99.76$, $p < .001$***	*d = .88 [.70–1.06]*
n (%) scoring above cut-off (≥ 10)	286 (64.1%)	36 (19.7%)	$\chi^2 = 102.63$, $p < .001$***	*v = .40*

Note: Mean (*SD*) [95% CI]. Childhood Trauma measured using CTS-5; Adulthood Trauma measured using ATS-5; PTSD Symptoms measured using PCL-6, Anxiety measured using GAD-7, Depression measured using PHQ-9. * p < .05, ** p < .01, *** p < .001

Gender differences were observed in overall trauma scores, with women reporting more trauma in childhood and adulthood than men (including when accounting for symptoms of depression and anxiety). A significant interaction of autism group (autistic vs. non-autistic) and gender (men vs. women) was observed. Autistic women reported elevated rates of overall trauma in childhood and adulthood compared to all other groups (autistic women > autistic men > non-autistic women > non-autistic men). The same pattern of results was found when accounting for current symptoms of depression and anxiety. See Supplementary Table 1.

Table 2 **HERE**

Specific trauma exposure in childhood and adulthood

The autistic group reported significantly higher rates on all specific types of childhood trauma compared to the non-autistic group, including emotional, physical, and sexual abuse. For trauma in adulthood, the autistic group reported significantly higher rates on emotional, physical, and financial abuse trauma types, but not sexual abuse. See Table 3.

Table 3
Self-reported rates of trauma (reported as 'sometimes' or higher) in the autistic and non-autistic group.

		Autistic group (*n* = 446)		Non-autistic group (n = 183)		Group Difference	Effect Size	Odds Ratio
CHILDHOOD	I [never] felt loved (R; emotional neglect)	275	(61.7%)	48	(26.2%)	χ^2 = 65.2, *p* < .001***	*v* = .32	2.35 [1.82–3.03]
	My family hit me so hard it left bruises or marks (physical abuse)	94	(21.1%)	16	(8.7%)	χ^2 = 13.68, *p* = .002**	*v* = .15	2.41 [1.46–3.98]
	I felt someone in my family hated me (emotional abuse)	176	(39.5%)	23	(12.6%)	χ^2 = 43.49, *p* < 001***	*v* = .26	3.14 [2.10–4.68]
	Someone sexually molested me (sexual abuse)	91	(20.4%)	16	(8.7%)	χ^2 = 12.50, *p* < 001***	*v* = .14	2.33 [1.41–3.86]
	Someone was [not] there to take me to the doctor when needed (R; physical neglect)	151	(33.9%)	37	(20.2%)	χ^2 = 11.52, *p* < 001***	*v* = .14	1.68 [1.22-3.00]
ADULTHOOD	I have [not] been in a confiding relationship (R; emotional neglect)	220	(49.3%)	49	(26.8%)	χ^2 = 26.96, *p* < .001***	*v* = .21	1.84 [1.42–2.38]
	My partner/ex-partner/someone close to me deliberately hit or used violence against me (physical abuse)	107	(24.0%)	25	(13.7%)	χ^2 = 8.35, *p* = .002**	*v* = .16	1.76 [1.18–2.62]
	My partner/ex-partner/someone close to me repeatedly belittled me to the extent that I felt worthless (emotional abuse)	179	(40.1%)	43	(23.5%)	χ^2 = 15.73, *p* < .001***	*v* = .16	1.71 [1.29–2.27]
	Someone has sexually interfered with me, or forced sex on me (sexual abuse)	98	(22.0%)	28	(15.3%)	χ^2 = 3.61, *p* = .058	*v* = .08	1.49 [1.07–2.08]

		Autistic group (n = 446)		Non-autistic group (n = 183)		Group Difference	Effect Size	Odds Ratio
	I've [not] had money for rent or mortgage payments (R; financial hardship)	127	(28.5%)	35	(19.1%)	χ^2 = 5.93, p = .015*	v = .01	1.48 [1.07–2.06]

Note. *N* (%) endorsing "sometimes" or more frequently. "*R*" items are reverse coded, with square bracketed words for context. ** p < .05, ** p < .01, *** p < .001.*

Some gender differences were observed in the specific types of trauma experienced. In childhood, autistic women reported significantly higher rates on all childhood trauma items compared to autistic men and non-autistic women. Non-autistic women reported more often reported experiencing emotional neglect than non-autistic men. In adulthood, autistic and non-autistic women reported experiencing more emotional and sexual abuse than non-autistic and autistic men, with autistic women reporting higher rates than non-autistic women. Autistic women were at a sixfold likelihood for experiencing sexual abuse compared to autistic men (OR 6.37 [3.50–11.60]), and non-autistic women were at a near fourfold likelihood for experiencing sexual abuse compared to non-autistic men (OR 3.82 [1.7–8.58]). See Supplementary Table 2.

Table 3 **HERE**

Symptoms of PTSD

The autistic group reported significantly higher current symptom scores of PTSD than the non-autistic group (including when accounting for symptoms of depression and anxiety). Additionally, a higher proportion of the autistic group versus the non-autistic group met cut-off criteria for current symptoms of PTSD (33% vs. 9%). See Table 2.

Gender differences were observed in PTSD symptom scores, with women reporting more symptoms of current PTSD symptoms than men (including when accounting for symptoms of depression and anxiety). There was not a significant interaction of autism group (autistic vs. non-autistic) and gender (men vs. women) in PTSD symptom scores. While autistic women reported higher symptom scores than autistic men (as well as other groups), these differences did not reach significance. However, more autistic women (39%) than men met cut-off criteria for current symptoms of PTSD than autistic men (26%). Men and women in the autistic group also had higher rates of above-cut off symptoms than non-autistic women (12%) and non-autistic men (6%). See Supplementary Table 1.

Associations between overall trauma and PTSD symptoms

For the autistic group, significant moderate positive associations were found between PTSD symptoms and childhood trauma ($r = .34$, $p < .001$), and PTSD symptoms and adulthood trauma ($r = .43$, $p < .001$), with no significant differences found in the strength of these associations ($z = 1.57$, $p = .12$).

For the non-autistic group, significant small positive associations were found between PTSD symptoms and childhood trauma ($r = .20$, $p < .001$), and PTSD symptoms and adulthood trauma ($r = .19$, $p < .001$), with no significant differences found in the strength of these associations ($z = 0.1$, $p = .92$).

Comparing groups, the strength of the PTSD symptoms and childhood trauma association was significantly stronger in the autistic group than the non-autistic group ($z = 1.71$, $p = .04$ one-tailed or .09 two-tailed). Similarly, the strength of association between adulthood trauma and PTSD symptoms was significantly greater in the autistic group than in the non-autistic group ($z = 2.97$, $p = .002$). See Table 4.

Table 4
Correlations by Autism Group and Gender between Overall childhood and adulthood trauma and PTSD symptoms; with Fisher's r-to-z Transformation for Group Comparison of Coefficients.

			r	Fisher's *r*-to-*z*
CHILDHOOD	*Group*	*Autistic (n = 446)*	.34***	$z = 1.71$, $p = .040$*
		Non-autistic (n = 183)	.20**	
	Gender	*Men (n = 269)*	.29***	$z = 1.69$, $p = .045$*
		Women (n = 360)	.41***	
	Group x Gender	*Autistic men (n = 199)*	.26***	$z = .80$, $p = .210$
		Autistic women (n = 247)	.33***	
		Non-autistic men (n = 70)	.09	$z = .93$, $p = .180$
		Non-autistic women (n = 113)	.23*	
ADULTHOOD	*Group*	*Autistic (n = 446)*	.43***	$z = 2.91$, $p = .002$**
		Non-autistic (n = 183)	.19**	
	Gender	*Men (n = 269)*	.34***	$z = 2.10$, $p = .020$*
		Women (n = 360)	.48***	
	Group x Gender	*Autistic men (n = 199)*	.32***	$z = 1.33$, $p = .090$
		Autistic women (n = 247)	.43***	
		Non-autistic men (n = 70)	.16	$z = .30$, $p = .380$
		Non-autistic women (n = 113)	.21*	

Note: * p < .05, ** p < .01, *** p < .001

Table 4 **HERE**

Post-hoc age stratification

A 2x2 ANOVA (Autism group, autistic vs. non-autistic; age group, midlife vs. old) was conducted to examine group differences in reported overall trauma scores and symptoms of PTSD. Age differences were observed in overall trauma scores and PTSD symptoms, with middle-aged adults reporting more trauma in childhood and adulthood than those in old age (including when accounting for symptoms of depression and anxiety). Significant interactions of autism group and age were observed. For overall trauma scores, autistic adults in midlife reported elevated rates compared to all other groups (autistic midlife > autistic old age > non-autistic midlife = non-autistic midlife; including when accounting for symptoms of depression and anxiety). No significant interactions of autism group and age were observed for current symptoms of PTSD (autistic midlife = autistic old age > non-autistic midlife = non-autistic old age). However, more autistic adults in midlife (37%) than old age (26%) met cut-off scores for symptoms of PTSD. The autistic groups also had higher rates than the non-autistic midlife (13%) and old age (4%) groups. See Supplementary Table 3.

When considering specific types of trauma, some differences were found. For childhood experiences, autistic people in midlife reported higher rates of physical, emotional and sexual abuse than autistic people in old age. Non-autistic people in midlife reported higher rates of emotional abuse than non-autistic people in old age. No other differences were found. For adult experiences, autistic people in midlife reported higher rates of emotional abuse than autistic people in old age. No other differences were found. See Supplementary Table 4.

Post-hoc regression

A post-hoc multiple regression analysis was conducted to examine the impact of autism group on PTSD symptom scores when controlling for age, gender and the rates of trauma experienced. In Block 1, the model including *age* and *gender* was significant, R^2 = .05, F(2,626) = 16.10. After entering symptoms of depression and anxiety in Block 2, the model significantly predicted PTSD symptoms ΔR^2 = .52, F (4, 624) = 370.74 with a further 52% of the variance in PTSD symptom scores were accounted for. When *Childhood* and *adulthood trauma scores* were entered in Block 3 the model continued to significantly predict PTSD symptoms, ΔR^2 = .02, F (6, 622) = 11.88. Finally, in Block 4, adding *autism group* significantly improved the model and further accounted for variance in PTSD symptom scores ΔR^2 = .01, F (7, 621) = 19.83 when controlling for age, gender, trauma and symptoms of depression and anxiety. In the final model, *autism group* (B = − .83, p < .001) was a significant predictor of *PTSD symptoms*, with autistic individuals reporting higher levels of PTSD symptoms compared to non-autistic individuals. Symptoms of depression (B = .28, p < .001) and anxiety (B = .41, p < .001), *childhood trauma* (B = .13, *p* = .009) also significantly predicted PTSD symptoms, although *adulthood trauma* (B = .11, *p* = .052), *gender* (B = − .59, p = .07) and *age* (B = − .02, *p* = .10) did not. See Table 5.

Table 5
Multiple regression model results for reported symptoms of PTSD

	B	SE B	β	95% CI	R^2	ΔR^2
Model 1					0.05***	0.05***
- *Age*	-0.08	0.02	− .16***	[-0.12, -0.04]		
- *Gender*	-1.50	0.47	− .13**	[-2.43, − .57]		
Model 2					0.57***	0.56***
- *Age*	-0.04	0.01	-0.06*	[-0.06, -0.01]		
- *Gender*	-0.56	0.32	-0.05	[-1.20, 0.80]		
- *Anxiety*	0.46	0.05	41***	[0.37, 0.55]		
- *Depression*	0.34	0.04	.37***	[0.26, 0.41]		
Model 3					0.58***	0.57***
- *Age*	-0.02	0.01	− .05	[-0.05, 0.00]		
- *Gender*	-0.33	0.32	− .03	[-0.96, 0.30]		
- *Anxiety*	0.43	0.05	.39***	[0.34, 0.52]		
- *Depression*	0.30	0.04	.33***	[0.23, 0.38]		
- *Childhood trauma*	0.15	0.05	.10**	[0.06, 0.25]		
- *Adulthood trauma*	0.12	0.06	.07*	[0.01, 0.24]		
Model 4					0.59***	0.59***
- *Age*	-0.02	0.01	− .04	[-0.05, 0.00]		
- *Gender*	-0.59	0.32	− .05	[-1.22, 0.40]		
- *Anxiety*	0.41	0.05	.36***	[0.32, 0.50]		
- *Depression*	0.28	0.04	0.30***	[0.20, 0.35]		
- *Childhood trauma*	0.13	0.05	.08**	[0.03, 0.23]		
- *Adulthood trauma*	0.44	0.07	.26***	[0.31, 0.58]		
- *Autism group*	-0.83	0.19	0.13***	[0.47, 1.12]		

Note: Childhood Trauma measured using CTS-5; Adulthood Trauma measured using ATS-5; * p < .05, ** p < .01, *** p < .001

TABLE 5 HERE

DISCUSSION

Using data from a sample of people in midlife and old age, this study documents the rates and experiences of trauma and symptoms of PTSD among 360 autistic adults aged 40 to 90 years old, compared to an age and gender-matched non-autistic comparison group. As hypothesised, middle-aged and older autistic adults reported significantly higher overall childhood and adulthood trauma scores, as well as significantly higher symptoms scores of current PTSD, than the non-autistic comparison group. Furthermore, autistic women reported significantly higher rates of abuse and neglect than autistic men and non-autistic women. Additionally, when exploring age differences, autistic people in midlife (i.e., aged 40–64 years) reported higher rates of overall trauma and PTSD symptoms when compared to autistic people in old age (i.e., aged 65 + years). Across these analyses, our results remained when accounting for symptoms of depression and anxiety. Finally, autism group membership continued to significantly predict PTSD symptom score severity when rates of childhood and adulthood trauma exposure were controlled for. Taken together, these results – which broadly replicate and extend the findings of Stewart et al.'s (2022) results from a high autistic trait (not diagnosed) sample – have important clinical considerations. Autistic people, particularly autistic women and autistic people who are middle-aged, may benefit from trauma-informed support to mitigate the impact of negative life experiences and PTSD symptoms on their mental health and wellbeing across midlife and old age.

Our study found that the middle-aged and older autistic adults reported higher rates of childhood and adulthood trauma than the non-autistic comparison group, a pattern which remained when accounting for symptoms of depression and anxiety. These higher rates of childhood and adulthood trauma were found in physical, sexual and emotional trauma and represented a near two-fold risk increase when compared to the non-autistic comparison group. Autistic women (compared to autistic men) and autistic people in midlife (compared to autistic people in old age) reported higher rates of traumatic life experiences, suggesting important gender and age considerations. In the general population, women and girls more often experience abuse and neglect in childhood and reported neglect and abuse has increased over the past several decades (World Health Organisation, 2024). Our findings indicate that autistic people may be particularly impacted by these societal trends.

When viewing the findings of the current study alongside the existing literature, our results are consistent with the rates of abuse and neglect reported in studies of younger autistic and non-autistic people (e.g., (Gibbs et al., 2023, 2024; Haruvi-Lamdan et al., 2020; Rothman et al., 2023; Rumball et al., 2020). Our findings are also comparable to the rates of trauma and abuse reported by Stewart et al.'s (2022) study involving high vs. low autistic trait adults aged 50 + years. Given the consistency of these findings across age groups and sampling approaches (i.e., diagnosed vs high autistic trait groupings), our findings add to the growing body of evidence that autistic people are more likely to experience physical, emotional and sexual abuse and trauma throughout their lives, highlighting the importance of services needing to be trauma-informed when supporting ageing autistic people..

The current study also found higher rates of PTSD symptoms in the autistic group when compared to the non-autistic group. These high rates also include meeting cut-offs for clinical levels, e.g. the autistic group were 3 times more likely to meet cut-off scores for current PTSD symptoms compared to the non-autistic group (33% vs. 9%, respectively). Interactions were also found in relation to gender and age; Autistic women reported elevated symptoms of PTSD compared to autistic men and non-autistic women. Additionally, an interaction

between autism and age group was found, placing autistic adults in midlife at higher risk for symptoms of PTSD compared to those in old age, perhaps reflecting an increase in awareness and disclosure of abuse over time. Importantly, these findings remained when accounting for depression and anxiety symptoms, which are associated with influencing how people self-report.

Our results are consistent with the 35% above cut-off for PTSD symptoms reported in Stewart et al.'s (2022) study of middle-aged and older adults with high autistic traits. These rates are also comparable to previous studies involving young autistic adults, e.g., 32–45% of autistic adults (Agebjörn et al., 2024; Andrzejewski et al., 2023; Haruvi-Lamdan et al., 2020; Reuben et al., 2021; Rumball et al., 2020, 2021). Additionally, the current study's finding of higher PTSD symptoms in autistic women is in keeping with the wider literature examining PTSD in the general population, which underscores women to have a two-to-three times higher risk of developing PTSD than men (Olff, 2017).

Another finding of our study was that the middle-aged and older autistic adults displayed a significantly stronger association between childhood and adulthood trauma with symptoms of PTSD than the non-autistic comparison group. Additionally, autism group membership continued to significantly predict PTSD symptom score severity when rates of childhood and adulthood trauma exposure were controlled for. These findings are consistent with and extend the existing literature on the relationship between traumatic life experiences and symptoms of PTSD in high autistic trait populations (Stewart et al., 2022) and young autistic adults (Andrzejewski et al., 2023; Haruvi-Lamdan et al., 2020; Rumball et al., 2021).

When considering why trauma exposure and PTSD symptoms may be so high in autistic populations, several factors may be implicated. It is plausible that autism's genetic aetiology and core symptomatic differences in social communication increase autistic people's vulnerability to experiences of interpersonal victimization (Douglas & Sedgewick, 2023; Reuben et al., 2021). The cognitive and sensory styles often found in autistic populations may also leave autistic people being more vulnerable to develop PTSD symptoms after a traumatic event (Rumball et al., 2020). Another consideration is the types of trauma that are often considered in clinical settings; despite meta-analyses indicating that suggest emotional trauma accounts for 74% of all instances of abuse in community-dwelling older adults (Yon et al., 2017), these non-traditional traumas may be overlooked clinically in autistic populations (as evidenced in the current study). Autistic individuals in midlife (aged 40–64) may report higher trauma levels than older adults due to generational differences in autism recognition (i.e., an undiagnosed autistic person being made to conform to neurotypical standards), greater awareness and reporting of past trauma, the impact of navigating rapid societal change, as well as potential survivor bias in older cohorts.

Additionally, increased vulnerability for trauma and PTSD among autistic women may reflect an interplay of biological (e.g., epigenetic, neurological, hormonal) and psychosocial factors (Hiscox et al., 2023). Women (and people assigned female at birth) often face greater barriers to autism diagnosis (Cruz et al., 2024), which can impact sense of self, coping, and mental health. Combined with higher exposure to gender-based trauma and limited access to adapted care, may elevate the risk of developing PTSD and other psychiatric conditions (Fox, 2024). Future studies should further explore the context of trauma in autistic adults – particularly those in midlife and among autistic women – including the victim-perpetrator relationship and the specific settings such as school, workplace or online environments to better inform targeted prevention strategies.

Furthermore, our finding that autism group membership remained a significant predictor of PTSD symptoms after controlling for trauma exposure may suggest that autism-specific mechanisms increase vulnerability to developing symptoms of PTSD (Quinton et al., 2024). Cognitive frameworks for trauma suggest that persisting psychological responses do not directly result from traumatic experiences, but rather emerge from the way one emotionally copes with these events (Brewin, 2001). Autistic individuals' detail-focused and sensory-driven processing styles (e.g., Happé & Frith, 2006) could also give rise to the persistence of adverse psychological responses by creating vivid, poorly contextualised memories easily triggered by one's surroundings (Rumball et al., 2021). It is also conceivable that these findings reflect 'diagnostic overshadowing' (Stavropoulos et al., 2018), whereby symptoms of PTSD such as hyperarousal, sensitivity to loud noises and emotional detachment are conflated with similar autistic traits (Al-Attar & Worthington, 2024). Future longitudinal studies are needed to disentangle core autistic traits from symptoms of PTSD, and further explore how autism-specific cognitive strengths and vulnerabilities are implicated in the development and maintenance of PTSD (Quinton et al., 2024).

When contextualising the findings of this study, it is important to consider the strengths and limitations of its design and implementation. For limitations, the use of an online self-report survey raises concerns about the reliability and generalizability of responses. Sampling biases may have occurred due to the age-related 'survivor effects,' as those who self-selected to participate likely represent older adults with higher socioeconomic status, better physical health and exclude older adults with intellectual disabilities, who experience higher rates of trauma and PTSD symptoms (Kerns et al., 2015; Kildahl & Helverschou, 2024). Further, our study was limited in using cross-sectional data, meaning we were unable to infer age-related change from these findings and may have only partially captured respondent's symptoms of PTSD, as PTSD symptom onset and course in the general population is often delayed, fluctuant, and influenced by contextual factors (Böttche et al., 2012). The use of gold-standard clinician-led assessments, such as the Clinician-Administered PTSD Scale (CAPS-5; Weathers et al., 2018) are required to provide reliable prevalence estimates of PTSD.

Despite these limitations, our study was strengthened by using diverse recruitment methods and inclusion of participants not specifically recruited for trauma and psychiatric difficulties (Quinton et al., 2024). Moreover, its inclusion of mostly diagnosed middle-aged and older autistic individuals (83%) addressed the call for research involving an often-neglected population in autism research. Finally, our results are consistent across cohorts with those reported in Stewart et al.'s (2022), reinforcing the validity of empirical findings involving high autistic trait adults in mid-life and old age (Stewart et al., 2020, 2023).

In conclusion, this study shows that middle-aged and older autistic adults often experience trauma throughout lives and often report high symptoms of PTSD. Autistic women and those in middle-age may be particularly vulnerable to both trauma and PTSD. Autism group membership remained a significant predictor of PTSD symptom severity even after accounting for trauma exposure, suggesting autistic people may be particularly susceptible to PTSD. Future longitudinal research should explore cognitive mechanisms, age-related changes, and the direction of the relationship between trauma and PTSD symptoms. As a growing but under-researched population, autistic adults in later life need evidence-based approaches to reduce trauma and promote post-traumatic resilience as they age.

Declarations

AUTHOR CONTRIBUTIONS

Authors RAC, FH and GRS conceived the AgeWellAutism study. GRS designed the online survey and selected materials. GRS conceived the current study. EMA and GRS conducted analyses. EMA wrote the manuscript under the supervision of GRS. AQ, RAC and FH reviewed and edited drafts of the manuscript. All authors have read and approved the final manuscript.

AVAILABILITY OF DATA AND MATERIALS

The data that support the findings of this study are held by Dr. Gavin Stewart, but the availability of these data is restricted. The data were used under license for the current study and are not publicly available. However, the data may be available from the authors upon reasonable request and with permission from Dr. Gavin Stewart.

CONFLICTS OF INTEREST

None to declare.

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