Childhood Sexual Abuse: A Review of Its Impact on Older Women Entering Institutional Settings

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ABSTRACT. Little is known and less is written about post-traumatic stress disorder (PTSD) in institutionalized older adults, especially in the context of their past exposure to child sexual assault. The behavioral and psychological manifestations displayed by child sexual abuse survivors are considered especially in the context of possible symptom reactivation throughout the life course. Analysis is offered of the ways in which aging itself and the organizational practices of long-term care institutions may serve to reactivate and exacerbate long-dormant child sexual abuse thoughts, feelings, and symptoms in residents. Specific recommendations for needed research as well as nursing home staff training, programming, and policy are put forward. [Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <http://www.HaworthPress.com> © 2003 by The Haworth Press, Inc. All rights reserved.]

KEYWORDS. Post-traumatic stress disorder (PTSD), child sexual abuse, aging and institutionalization

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INTRODUCTION

This is a review of post-traumatic stress disorder (PTSD) in older people. This topic is seldom addressed in the literature and when it is addressed attention is usually focused on the development of PTSD in war veterans or in survivors of natural disasters. There appears to be virtually no literature that addresses this disorder in older men or women exposed to sexual assault during childhood (McCartney & Severson, 1997).

In 1998 the first author (Jay Peters) was asked to include information on the differential diagnosis of post-traumatic stress disorder and dementia as part of a day-long staff training on working with adult survivors of childhood sexual abuse. A review of the literature at that time revealed that there were only a handful of articles on the subject, most of which were single case reports. During the training, staff members working with older women commented on the many ways in which the practices of the institutions in which they worked could be seen as replicating the dynamics of child sexual abuse. For example, workers described how residents usually had little or no control over who could walk into their room at any time, who saw their naked bodies, or who touched them where or how. The workers speculated that certain institutional practices might evoke and exacerbate feelings and symptoms related to undisclosed child sexual abuse.

In the years since that training, the literature on PTSD among aged female survivors of child sexual abuse has grown by only a few articles. Each of those articles laments the lack of research and empirical knowledge available, and then limits analysis to one to three case examples (e.g., Gagnon & Hersen, 2000). In contrast with this meager literature is an enormous client population. Highly regarded epidemiological research indicates that from 25% to 33% (Saunders, Villeponteaus, Lipovsky, Kilpatrick, & Veronen, 1992) and as many as 42% of women are sexually abused before age 18 (Randall & Haskell, 1995) with 9% experiencing persistent, genital assault (Epstein, Saunders, Kilpatrick, & Resnick, 1998). Given these disturbingly high rates of sexual assault of children, we can assume that among the institutionalized aged and older individuals seeking professional services, a significant proportion are survivors of child sexual abuse. The disparity between the large number of elder child abuse survivors and the existing literature would appear to represent a significant gap in our knowledge. As a result, a series of questions remain unanswered. What are the common symptom profiles of elder child sexual abuse survivors? What institutional practices serve to ame-
What are the implications for policy, programming, and clinical practice of increased awareness of the needs of elder child sexual abuse survivors?

This article brings together the existent literature on child sexual abuse, post-traumatic symptoms, aging, and common practices in institutional settings as they may relate to child sexual abuse survivors. Specifically, we begin by exploring post-traumatic symptoms and their possible reactivation throughout the life course. Then, after a brief review of the prevalence, onset, and duration of child sexual abuse, we consider the interpersonal dynamics involved in child sexual abuse and the impact of that abuse on the victim. This review lays the foundation for a detailed analysis of the ways in which aging itself and the practices of institutions working with older adults may serve to replicate and thus reactivate or exacerbate long-dormant child sexual abuse thoughts, feelings, and symptoms. We conclude with specific recommendations for staff training, programming, and policy.

**LONG-TERM EFFECTS OF TRAUMATIC STRESS**

*The Symptoms*

Most people who have experienced serious trauma endure some admixture of the twin scourges of numbing and intrusion. Indeed the alternation between periods of numbing of responsiveness and intrusive recall is called the dialectic of trauma (Herman, 1992) and is considered the hallmark of traumatic stress responses in general and post-traumatic stress disorder (PTSD) specifically (American Psychiatric Association, 1994). Within the dialectic, common symptoms include “distressing flashbacks, startle responses, nightmares and night terrors, partial amnesia and fragmented memories, affective flooding and numbing, self-destructive behaviors, and intense self-loathing” (Pearlman & Saakvitne, 1995, p. 92). Additional symptoms include intrusive recollections, intense psychological distress, psychic numbing, feeling detached from people, difficulty falling or staying asleep, hypervigilance, exaggerated startle response, difficulty concentrating, irritability, and (less frequently) aggression (American Psychiatric Association, 1994). This lengthy symptom list is itself a testament to the potential seriousness and complexity of post-traumatic effects.
Variation and Reactivation

For the purposes of this article, it is important to understand that post-traumatic symptoms are not an inevitable consequence of trauma. Many individuals endure warfare, rape, or sexual assault without developing long-term symptoms (Gentlewarrior, 1998; King, King, Foy, Keane, & Fairbank, 1999; see Calhoun & Resnick, 1993, for a review of the literature). Paradoxically, for individuals who do develop PTSD, the effects may last an entire lifetime, with some or many of the above symptoms persisting 30 years (Saunders, Villeponteaus, Lipovsky, Kilpatrick, & Veronen, 1992) to 50 years (Clines, 1995) post trauma. The symptoms, however, are rarely constant, but rather fluctuate throughout the life-span in response to natural healing and recovery, anniversaries, or developmental milestones such as retirement (Reich, 1996). Symptoms may also be reactivated or exacerbated by exposure to events or objects, which symbolize the traumatic event-triggers.

THE EXTENT AND NATURE OF CHILD SEXUAL ABUSE

Prevalence, Onset, Duration, and Frequency

Prevalence

Because child sexual abuse is an activity shrouded in (and often defined by) secrecy (Herman & Hirschman, 1981), the exact prevalence is difficult to ascertain. Reports to police and child welfare officials are thought to grossly underrepresent the true incidence, while retrospective self-reports are subject to the dual possibilities of under- or overreporting. In addition, rates of child sexual abuse reported by adult research subjects can vary based on the data collection methodology used (Peters, Wyatt, & Finkelhor, 1986), with telephone surveys reporting the lowest rates compared to lengthy in-depth interviews (Peters, unpublished data). Finally, the rates reported depend on the definition of child sexual abuse employed, with some studies using a criteria of forcible penetration (Epstein, Saunders, Kilpatrick, & Resnick, 1998) while others use more inclusive definitions, including all sexualized behavior initiated by someone five years or more older than the victim (Long, 1997).

Using the most conservative definition and a national stratified sample, Epstein and colleagues found that 9% of women reported actual rape in childhood, including forcible penetration (Epstein, Saunders, Kilpatrick, & Resnick, 1998). Studies that define the sexual assault
more broadly to include any physical sexual contact by a relative or someone five years older than the victim have found that between 21% to 47% of adult women were sexually assaulted during childhood (see Table 1).

Unless women who are sexually abused in childhood suffer dramatically higher mortality rates, we can estimate from this review of the literature that approximately one in three older women are survivors of early childhood sexual trauma and approximately one in ten are survivors of more severe genital abuse, including rape.

**Onset, Duration, and Frequency of Abuse**

The age of onset of childhood sexual abuse is reported with great consistency as occurring most frequently between 7 and 10 years of age (Cole & Putnam, 1992; Elliott, Brown, & Kilcoyne, 1995; Gelinas, 1983; Goldman & Padyachi, 1997; Herman & Hirschman, 1981; Lanktree & Briere, 1995; Ussher & Dewberry, 1995). No matter what the age of onset, unfortunately, the duration of most child sexual abuse is not brief. Faller (1989a, p. 224) found that the average duration was 3.6 years if the perpetrators were biological fathers, 2.4 years for common law or stepfathers, and 1.9 years for non-custodial fathers. The mean duration across all relationship types has been reported as 2.7 years (Faller, 1989a) to 3 years (Herman & Hirschman, 1981). While Ussher and Dewberry (1995) found a similar pattern of duration dependent on the abuser’s relationship with the victim, they found an even longer average

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duration of abuse of 6.9 years for fathers or stepfathers and 5.2 years for other perpetrators.

During these years, abuse appears to occur quite frequently. Faller found that prior to disclosure of the abuse, children were sexually abused an average of 34.4 times by biological fathers, 26.4 times by common law or stepfathers, and 19.1 times by non-custodial fathers (1989a). When combined with the mean duration of the abuse, these figures indicate that the “average” child sexual abuse victim is raped or assaulted about once a month over the course of several years. Thus for the majority of elderly survivors of child sexual abuse, the abuse was probably not an isolated event but rather a recurrent event extending for what was at that time, one-quarter to one-half of their entire lifetimes.

With onset around age nine and a duration of approximately three years, child sexual abuse typically occurs at what might be considered a particularly meaningful phase of life—the time of developmental transition from latency into puberty and adolescence (Marano, 1997). This association of child sexual abuse and difficult life transition may mean that the similarly difficult life transition of entrance into an institution may re-awaken unresolved thoughts, feelings, and coping mechanisms related to the sexual abuse.

Taken together, data on the prevalence, age of onset, and duration of most child sexual abuse indicates that the problem may be greater than generally believed. Indeed, child sexual assault is an endemic problem, effecting approximately a third of all women in this country. Nor is it a fleeting problem for most women. Rather it usually continues unabated for three to six years, during which time the child or young woman is sexually assaulted on a regular and frequent basis. These already difficult aspects of child sexual abuse are compounded by the fact that the abuse is usually perpetrated by the girl’s father, father substitute, or close friend of the family. Approximately a third of the women in this country have, therefore, endured regular, frequent, and protracted violation and relational betrayal.

The Nature of the Abuse

A Family Matter

Contrary to the popular conception, most sexual abuse of female children is perpetrated not by a stranger but by biological fathers (Herman & Hirschman, 1981; Russell, 1984), stepfathers (Faller, 1989b; Gordon, 1989; Russell, 1984; see Fleming, Mullen, & Bammer, 1996, for contrary findings) and other male relatives. More surprising yet is that in the majority of the above studies, biological fathers are usually found to
be the most frequent perpetrator. However, when exposure to stepfathers is controlled for, a child is more than six times more likely to be abused by a stepfather than a biological father, if they are the primary parent (Russell, 1984).

Regardless of the exact nature of the relationship, the perpetrator of child sexual abuse is most commonly a father figure or other close relative. For most victims, child sexual abuse, therefore, involves a profound betrayal of trust (Freyd, 1996) by someone on whom the child must depend, and to whom they must entrust their physical care and safety.

Subsequent to that betrayal, the child may mourn the loss of their good image of the parent (Cole & Putnam, 1992; Reichert, 1994). Though the loss of the good image is less absolute than loss through death, the grieving dynamics are similar, leaving the child to “cope as best he can with a confusion of guilt, anger and an outraged sense of abandonment” (Alvarez, 1970, p. 110). But because that anger has no available outlet (to get angry at the perpetrator may be perceived as too risky), it usually remains “bottled up,” and becomes a free-floating entity directed alternately at the self or (much more rarely) at others. As a result, “these victims have extreme difficulties with anger and aggression, self-image, and trust” (Carmen, Rieker, & Mills, 1984, p. 382).

The elder female survivor of child sexual abuse is thus someone who may have endured repeated, prolonged, and frequent betrayal by a previously “passionately and helplessly” loved parent. She may, therefore, be well attuned to real or even imagined betrayals of trust by caretakers, to which she may respond with what appears to be disproportionate anger. At the same time the older survivor may resort to previously life saving splitting in relation to authority figures (“they are good, I am bad”) and may then blame herself for any maltreatment.

Depression and Dissociation

For the child, child sexual abuse usually involves many profound losses; the loss of her good image of the offending parent; of innocence, trust, a sense of safety in the world, of a childhood, which can be idealized, and of unalloyed loving feelings toward the previously “good enough” parent. Given the enormity and number of these potential losses, it is not surprising that depression is the most frequently cited sequela of child sexual abuse (see Browne & Finkelhor, 1986, for a review of the literature; see also Burnam et al., 1988, who found that major depression was both a precursor and sequela of abuse).
In order to ward off all these losses and the subsequent depression, most child victims blame themselves, not the parent, for the abuse (Carmen, Rieker, & Mills, 1984; Miller & Stiver, 1996). Such self-blame, however, carries a price in that the child must distort her lived reality in order to preserve the good image of the parent. This distortion of reality usually involves some degree of dissociation in which the child says, in essence, “this is not happening” (Ross, 1989).

Dissociation is the preeminent defense mechanism for dealing with incompatible realities. Children being abused are constantly confronted by unresolvable contradictions: the parent who abuses them is frequently also the most loving and nurturing parent (Walker, 1994); the same parent who jokes lightly at the breakfast table hurts her sadistically at night (Davies & Frawley, 1994); and despite her fear and anger, she loves that parent. Growing up in these incompatible realities, “the child must find a way to preserve a sense of trust in people who are untrustworthy, safety in a situation that is unsafe, control in a situation that is terrifyingly unpredictable, power in a situation of helplessness” (Herman, 1992, p. 96). Dissociation is the technique of choice in such circumstances.

Unfortunately, while frequent use of these dissociated states of consciousness makes survival possible, it also leaves the child (and later the adult who continues to rely heavily on dissociative defenses) vulnerable to further misperceptions of reality due to the fragmentation of their perceptions and memories (Kluft, 1990). This tendency to misperceive threatening behavior, in combination with a common inclination to doubt the reality of their experience and to blame themselves for maltreatment, leaves adult child sexual abuse survivors at greatly increased risk of revictimization (Burnam et al., 1988; Éther, Lacharté, & Couture, 1995; Frieze, 1983; Fromuth, 1986; Randall & Haskell, 1995).

Paradoxically, while the habit of dissociation and misperception of reality may increase adult child sexual abuse survivor’s risk of revictimization, dissociation usually decreases with age (Bernstein & Putnam, 1986). Older female survivors may, therefore, be vulnerable to traumatic memories and affects “leaking through” previously effective dissociative barriers.

For an elder child sexual abuse survivor, institutionalization may revive feelings (especially depression) related to previous abuse through entry into a situation in which she must, despite residual mistrust, depend again on others for basic bodily needs such as the preparation of meals, washing, and other caretaking. In addition, she enters a situation in which she has relatively little power compared to those around her: a possible recapitulation of the abuse experience for most child sexual
abuse survivors. If she never previously had the opportunity to overcome difficulties with anger and aggression, she may respond to institutionalization with apparently inappropriate and misdirected anger. The older survivor may also be at increased risk of revictimization while simultaneously less able to use previously effective defenses to cope with either the original trauma or the new one.

Use of Force in Child Sexual Abuse

A common clinical assumption about intrafamilial sexual abuse is that it is not characterized by the use of force. In fact, while bribery, cajoling, “grooming,” and a host of other techniques are frequently used by abusers to gain compliance and compel the silence of their victims (Élliott, Brown, & Kilcoyne, 1995; Sgroi, Blick, & Porter, 1982), use of force by fathers, stepfathers, uncles and other family members appears to be the norm, not the exception (Herman & Hirschman, 1981; Sgroi, Blick, & Porter, 1982). Faller (1989a), for example, found “that paternal caretaker’s methods of gaining their victim’s cooperation were characterized by threats and force” (p. 227; see also Reto, 1997). Faller concludes: “what is . . . disconcerting about these data is how coercive all of the [abusive] paternal caretakers were, regardless of their relationships with the victims” (1989a, p. 227).

Abusers frequently use force and threats of harm not just to gain compliance from the victim but also to enforce her silence. While most threats are of relational disconnection through separation, divorce, or jail (Herman & Hirschman, 1981), abusers also frequently threaten to kill whomever the child holds most dear. In order to drive home the point, many abusers kill beloved pets, or shred favorite (and comforting) stuffed animals (Chase, 1990). Use of force in all its guises is even more frequent if the abuser was a father or stepfather or when the abuse involved intercourse (Ussher & Dewberry, 1995, p. 182).

To the extent that institutional staff must compel the resident to do something she does not want to do or prevent her from doing what she does (Adams, 1990), they may be perceived to use some form of coercion. Even if staff perceive their act to be something as benign as gentle guidance applied to an elbow, for an older abuse survivor, such guidance may re-evoke intense somatic memories of having her hand or head “guided” in the direction of the abuser’s genitalia. Even more important, such “guidance” is likely to re-evoke one of the prominent feelings of all victimization–loss of choice. This point cannot be overstated.
In fact, Ussher and Dewberry (1995) assert that “a focus on the context of the abusive relationship, the methods of maintaining secrecy, and the consequences of coercion is central to understanding the impact of child sexual abuse” (p. 88). To further our understanding, what should be emphasized is simply that “psychological trauma is an affliction of the powerless. At the moment of trauma the victim is rendered helpless by overwhelming force” (Herman, 1992, p. 33).

All forms of abuse, at bottom, involve one person usurping freedom of choice from another person. To be abused is to “feel physically and morally helpless” (Ferenczi, 1932, p. 297). To the extent that institutional policies and procedures remove choice from the resident, making her feel physically and morally helpless, they risk recreating the major dynamics of previous victimization. When choice is removed through coercion, no matter what the benign intent, the original victimization has been reenacted. While coercion is deleterious to most people, for elder child sexual abuse survivors it is likely to have specific meanings related to the abuse. When choice is removed, old feelings, memories, and responses characteristic of the response to child sexual abuse may reemerge.

Not Just Sexual Abuse

It is also important to understand that child sexual abuse rarely occurs in what is otherwise a perfect, “Leave it to Beaver,” family. Instead, child sexual abuse usually (but not always) occurs within a broadly pathogenic context (Nash, Hulsey, Sexton, Harralson, & Lambert, 1993), in which power and control are exerted through physical, psychological, and emotional abuse (Bryer, Nelson, Miller, & Krol, 1987; Fleming & Watts, 1980; for a contradictory view, see Gentlewarrior, 1998). In their study of incest, Herman and Hisrchman report that most survivors “described their fathers as perfect patriarchs. They were, without question, the heads of their households. Their authority within the family was absolute, often asserted by force” (1981, p. 71). Sexual abuse thus usually occurs in a context in which a male authority figure uses child sexual abuse and domestic violence (Graziano, 1992) to enforce hierarchy (Briere & Runtz, 1988; Putnam, Helmers, Horowitz, & Trickett, 1995; Sgroi, Blick, & Porter, 1982). As a result, children who are sexually abused usually live in “an environment that is devoid of care, safety, and affection, but is filled with fear, loneliness, confusion, and distrust” (Fleming, Mullen, & Bammer, 1996, p. 56).
Through her ethnographic research, Riemer (1997) found support for the common perception of geriatric nursing facilities as hierarchical institutions in which staff frequently regarded each other with fear, confusion, and distrust. In addition, while nursing aids “are the backbone” of the institution (p. 228), both the work and the aids themselves were held in low esteem when compared to the much higher status of licensed nurses. If the institution that the aged child sexual abuse survivor enters is similarly characterized by hierarchy, status differential, fear, and distrust, the institution may unwittingly replicate the family environment in which she was originally abused. This replication conceivably may act as a trigger, setting off thoughts, feelings, memories, and somatic reactions associated with the original abuse.

**FACTORS ELICITING ABUSE MEMORIES IN OLDER ADULTS**

*Influence of Normative Development*

Erikson, in both his initial (1980) and more recent (1994) delineations of the stages of life, conceives of old age as a time for coming to grips with the meaning of one’s life. This making meaning helps the individual achieve “ego integrity [and] emotional integration . . .” (Erikson, 1980, p. 105) but naturally requires extensive life review and reminiscence. For older survivors of child sexual abuse, however, while such “reminiscence is a normal task of old age . . . [it] may heighten a survivor’s vulnerability to unresolved child sexual abuse” and thus “reopen psychic wounds” (Gagnon & Hersen, 2000, p. 191). For some survivors, in fact, it appears they may become haunted, not healed, by their reminiscences (Gagnon & Hersen, 2000).

In addition to this natural inclination to life review and resulting elevated risk of reactivating trauma memories, formal reminiscence or life-review therapy is a common adjunctive treatment for institutionalized older adults. As indicated above, such therapies run the risk of bringing into consciousness long-repressed thoughts, feelings, and memories related to child sexual abuse. Workers engaged in such therapies, therefore, need to be prepared for and know how to handle possible disclosures. In addition, staff should be aware that even in the absence of an overt disclosure, reminiscence treatment may “reopen psychic wounds,” leading to exacerbation of PTSD symptoms of hyperarousal, anxiety, depression, and avoidance. For survivors who have previously
disclosed their child sexual abuse history, life-review therapy can be very effective, especially when conducted by workers who can help the survivor avoid becoming overwhelmed or flooded (McInnis, 1996).

**Impact of Entering the Institution**

**Physical Losses**

Physical losses attendant to entering an institution include, for many individuals, the home in which they may have lived for many years. To the degree that their home was free of domestic violence and abuse by adult children, the elder child sexual abuse survivor entering the institution may have lost an island of safety, a physically protected space in which she felt safe. While loss of “home” is difficult for most older adults, it is suggested that being without that external security provided by their home may reawaken abuse-specific feelings of vulnerability and lack of protection for older child sexual abuse survivors.

It can be argued that relative loss of mobility and freedom of movement may also have particular meanings for older child sexual abuse survivors. It is not uncommon for girls being abused to end the abuse by running away, moving in with relatives, or enacting other “geographic cures,” which are available because of her increased freedom and mobility. To have that mobility suddenly curtailed may trigger feelings related to the abuse of being, once again, trapped. As such, the loss of mobility may activate previously dormant thoughts, feelings, and memories of the abuse. Clinically, such an analysis suggests that one should look for signs of agitation, irritability, restlessness, or anxiety.

**Lack of Privacy**

Entrance into an institutional setting involves a loss of privacy and personal space. In the literature, this loss is generally considered under the heading of losses to be mourned. For child sexual abuse survivors, however, the loss of privacy and personal space may have additional meanings.

Child sexual abuse survivors often describe the perpetrator watching them as they sleep, spying on them in the bathroom, and generally violating all privacy boundaries (Herman & Hirschman, 1981). Perpetrators often report using bathing and toileting as opportunities when they would intentionally “groom” the child for later abuse by introducing and “normalizing” sexual touching as part of everyday activities (Elliot,
Browne, & Kilcoyne, 1995; Sgroi, Blick, & Porter, 1982). In addition, many survivors also report that the abuser would awaken them to engage in abuse (see, for example, Davies & Frawley, 1994).

For the older abuse survivor entering the institutional setting, the impact of the sudden loss of personal space may be much more pragmatic than metaphorical. Suddenly, she (again) may experience loss of control over the people who come, whenever they choose, into her personal space and view (“checks”), wash, wipe, touch, or insert (medical) objects into her body. Clearly, such practices may symbolically replicate previous familial abuse by fathers, older brothers, or other relatives, potentially reactivating post-traumatic symptoms (Reich, 1996).

**Social Losses**

The loss of social relationships, often involving longtime friendships, can create serious stress for the older person entering an institution (Harel, 1988). This stress, in turn, has been shown to frequently precipitate depression (Harel, 1988). In a disturbing “Catch 22,” depression then makes the individual less interested in or able to participate in mutual relational exchanges (Freud, 1917/1963; Kaplan, 1984), thus leading to further withdrawal from relational connection. For women, at least, the feeling that they have not been mutually involved in creating and maintaining relationships often leads to generalized feelings of guilt and shame (Surrey, 1984) and specifically to a loss of “zest” or energy; feeling less empowered to act beyond the relationship; decreased clarity and knowledge of self and other; and decreased ability to act (Miller, 1988).

As noted previously, depression is the most commonly reported aftereffect of child sexual abuse (Browne & Finkelhor, 1986; Gelinas, 1983; Saunders, Villeponteaus, Lipovsky, Kilpatrick, & Veronen, 1992; Silverman, Reinherz, & Giaconia, 1996; Zlotnick, Ryan, Miller, & Keitner, 1995) and is widely considered to be easily reactivated in the face of subsequent stress or loss. Thus, older child sexual abuse survivors entering an institution may be more vulnerable than other older women to depression subsequent to relational losses (Harel, 1988; Reich, 1996; see Walter, 1992; Gagnon & Hersen, 2000, for case examples).

While participation in a web of relationships can be an effective antidote to depression in women (Stiver & Miller, 1988), casual social interaction has been shown to have only a minimal impact on well-being (Harel, 1988). Consequently, for older child sexual abuse survivors en-
tering an institution, programmatic efforts to engage women in social exchange may be expected to have little beneficial impact—at least initially. As a whole, the loss of peer support, loss of roles, and loss of resources commonly encountered by older adults (especially institutionalized aged) may exacerbate child sexual abuse symptoms and aftereffects (Allers, Benjack, & Allers, 1992).

Other Losses

Related to both physical and social losses is a frequent loss of rituals, which is likely to occur when someone enters an institutional setting. These rituals may be the simple daily behaviors of making morning tea or coffee, emptying the garbage, and washing dishes. These rituals may also mark larger units of time—from weekly food shopping, or laundry to annual rites associated with the passing seasons such as spring cleaning, and fall “buttoning up.” While such tasks are often perceived as odious burdens, as ritualized behaviors they also provide an underlying structure and coherence to the days, weeks, and months. Loss of rituals can be an important loss for anyone. For survivors who have used the structure of rituals to buttress an internal organization made precarious by potentially overwhelming thoughts, feelings, and memories associated with the previous abuse, the loss of rituals may be even more destabilizing.

Family Reactions

In addition to the individual losses that accompany institutionalization, family patterns that accompany institutionalization of an older relative may approximate family dynamics that commonly occur when a child discloses sexual abuse in the home. When institutionalizing an older relative, family members frequently experience guilt, anger, and hostility, all in the context of a crisis within the family. Disclosure of intrafamilial sexual abuse is similarly described as provoking a crisis within the family (Burgess, Hartman, & McCormack, 1987); a crisis that often evokes intense guilt, free-floating anger, and generalized hostility in family members (Everson, Hunter, Runyon, Edelsohn, & Coulter, 1989). In both cases, just when the survivor is most in need of family support, love, and protection, family members may respond with anger and withdrawal driven by their feelings of guilt and hostility.

Familial hostility and withdrawal can be expected to be painful for most older adults entering an institution. For the older child sexual
abuse survivor who disclosed the abuse to their families, however, if family hostility is again experienced during the course of institutionalization, it may evoke a painful past and, therefore, have an even stronger impact.

While entering an institution involves losses for everyone, in this section we have shown that the losses may have particular meanings and effects for older child sexual abuse survivors. We postulate that loss of a house or apartment may evoke thoughts and feelings related to being vulnerable and unprotected; loss of social contacts may exacerbate child sexual abuse related depression; and loss of rituals may destabilize an already fragmented personality. In similar fashion, loss of family support may replicate previous familial abandonment. In such circumstances, we might anticipate observing elevations of anxiety, tearfulness, increased startle response, depression, suicidality, forgetfulness, and bizarre behaviors.

Impact of Institutional Practices

In the small, though growing, literature on aging trauma survivors, the cases discussed involve women presenting to outpatient psychotherapists (Allers, Benjack, & Allers, 1992; Gagnon & Hersen, 2000), or in institutional settings (Allers, Benjack, & Allers, 1992; McCartney & Severson, 1997; Walter, 1992). Though not stated explicitly, there appears to be an assumption in the literature that if a successful transition to the institution can be effected, then trauma-related issues have been dealt with. It is almost as if we view the institution as a safe haven in which no further trauma occurs or is re-evoked.

We argue that on the contrary, numerous situational factors and practices found in institutions for older adults may either serve to re-traumatize traumatic material or may result in the direct experience of trauma.

Coercive Behavior by Staff

Previously, we argued that behavior by staff that compelled the resident to do something against her will might re-evoke traumatic memories because trauma, at heart, is about coercion. We would suggest here that there may be an exceedingly wide range of common staff behaviors, which, from a trauma perspective, might be read as coercive and, therefore, potentially be retraumatizing to older child sexual abuse survivors in institutional settings. Included here may be necessary institutional policies and practices for insuring resident well-being such as requiring
that residents return to their rooms for rest at particular points during the
day, extinguish lights at prescribed hours of the night, eat meals at des-
ignated tables and times, adhere to medication regimens, and dress in
appropriate clothing when leaving facility grounds. More obvious, yet
sometimes necessary, coercive behavior includes use of restraints, physi-
cally directing a resident, or preventing someone from hurting herself.
For abuse survivors, any and all coercive behavior that usurps the resi-
dent’s freedom of movement may reactivate trauma-related thoughts,
feelings, and symptoms.

Sexual Assault in Institutional Settings

McCartney and Severson (1997) note that most discussion of PTSD
and trauma in older adults is focused exclusively on veterans or survi-
vors of natural disasters. They find irony in this trend when contrasted
with “a sizeable literature on sexuality in nursing home populations,”
including nonconsensual sex (p. 76).

As mentioned previously, a consistent finding in the literature on
sexual assault is that child sexual abuse significantly increases the risk
of subsequent rape during childhood (Boney-McCoy & Finkelhor, 1995;
Étheir, Lacharté, & Couture, 1995; McClellan, Adams, Douglas, McCurry, &
Storck, 1995), adolescence (Fromuth, 1986), and adulthood (Browne &
Finkelhor, 1986; Burnam et al., 1988; Frazier, 1990; Frieze, 1983;
Herman, 1984; Kluft, 1990; Randall & Haskell, 1995; Roberts & Lie,
1989; Russell, 1995). Among adults, the risk of revictimization is elevated in
large part because of the numerous ways in which enduring monthly
rape for three to six years as a child “forms and deforms the personality”
(Herman, 1992, p. 96).

While we know of no literature that exists concerning rates of
revictimization of older adults, the many cognitive and psychological
factors that predispose victims to revictimization (Davies & Frawley,
1994; Kluft, 1990) are likely to be unchanged as the adult enters later
adulthood. We would, therefore, postulate that women previously
abused would be at an elevated risk of revictimization within an institu-
tional setting. The effects of rape have almost exclusively been studied
among younger to middle-aged women (Burgess & Holmstrom, 1974;
Calhoun & Atkinson, 1991; Rose, 1986), leaving us with almost no
knowledge of the effects of sexual assault on older women. If the case
reported by McCartney and Severson (1997) is found to be typical,
however, we will find that the effects of rape experienced by older
women may well be pervasive and debilitating, often leading to severe restrictions in independence and quality of life.

In the portrait we have drawn to this point we have argued that compared with non-traumatized older women, older trauma survivors may be more vulnerable on entering institutional life, more negatively impacted by institutionalization, and then more likely to be retraumatized in the institution. Next, we examine the impact of how others may be expected to respond to the survivor’s distress.

**Staff Response to Flashbacks**

Under the circumstances just described, it is possible that the elder resident will have flashbacks to the abuse. Flashbacks are variable, but involve some degree of reexperiencing of the original trauma. Cognitive behavioral approaches have, especially since the advent of managed care, come to dominate most institutional settings. One of the fundamental assumptions of this approach is that clients have the ability to control what they think about (Feldman, 1995). Flashbacks, however, tend not to be under voluntary control and are, therefore, less amenable to behavioral plans. If staff maintain a distant, behaviorally oriented “professional stance” while the survivor endures the horror of the reexperienced abuse, it is suggested that staff are unwittingly recreating the environment of the family of origin in which the child’s horror and distress were ignored. This response, by “severing the last link” to human and humane connection (Ferenczi, 1932/1992, p. 296) may exhume yet more traumatic material, resulting in an escalation of symptomatic behaviors.

**Negative View of Staff**

“Our societal stereotype of older adults as unlovable, unattractive, and bothersome does nothing for an elder’s waning self-esteem” (Walter, 1992, p. 15). We would go further. Child sexual abuse victims frequently report feeling precisely “unlovable, unattractive, and burdensome” to others (Sgroi, Blick, & Porter, 1982). We would thus suggest that aging puts the survivor in the position that the view reflected of herself by society is exactly the view of herself she may have held when she was younger. To the extent that staff consciously or unconsciously endorse the socially dominant views of the elderly, they may increase the risk of reawakening or reinforcing the elderly survivor’s psychological negative self-appraisal. For survivors this negative self-appraisal may,
in turn, be accompanied by reactivation of intense abuse-related shame, which involves “a felt sense of unworthiness to be in connection, a deep sense of unlovability” (Jordan, 1989, p. 6). Feeling unworthy of love, we may find that elderly abuse survivors in such circumstances are more likely to withdraw into a depressed and withdrawn state with an accompanying loss of will to live.

**IMPLICATIONS**

**Implications for Long-Term Care Facility Policy and Practice**

The issues raised in this article underscore the importance of administration and staff in long-term care institutions directing more attention to the implications of their policies and practices for elder resident well-being. Comprehensive assessments of older adults entering long-term care institutions should reflect sensitivity to the early life experiences of those persons. A thorough assessment would be expected to address a wide range of potentially traumatic early life experiences that have impacted the lives of elder residents, including child sexual abuse. At the least, it should not be assumed that early life traumas have been resolved in all cases or that the experience of transition to institutional life will not cause a revisiting of those events and feelings for the older resident.

It is suggested that in-service training and continuing education for long-term care staff should assign higher priority to the issues raised in this analysis, including an increased understanding of the symptomatology, the role played by families, the potential impact of negative views and coercive behaviors displayed by staff, the meaning of loss and privacy, and the relocation event itself on the lives of elder residents with histories of child sexual abuse.

Long-term care personnel, in particular, need to appreciate the value of older residents maintaining a sense of control and mastery over their immediate or micro-environment. To the extent that the older resident experiences some measure of autonomy and empowerment, no matter how limited or fleeting, can make a significant difference in the quality of their experience in the nursing home. Indeed, the crucial importance of these individuals feeling they retain some control over their circumstances cannot be overstated. To that end, nursing homes and homes for the aged that emphasize resident engagement and active voice in the daily functioning and decision making of the institution are, we would
suggest, likely to represent living environments that are more inviting for elder victims of child sexual abuse, and for all residents for that matter.

**Implications for Research**

The sparse literature on elderly survivors of child sexual abuse means that we have an enormous research agenda ahead of us. There are a myriad of important questions that need our attention. What is the prevalence of child sexual abuse among institutionalized elderly? What are the best ways of assessing and addressing this history? Are the effects of child sexual abuse the same for women born in the 1920s and 1930s as for the survivors born in the 1950s, 1960s and 1980s who have been so widely studied? How has the meaning attached to the events changed over time? Do the changes in circumstances and meaning, if any, create different symptom profiles? What is the prevalence of symptoms such as flashbacks, intrusive recall, numbing, dissociation, anxiety, or depression among elderly child sexual abuse survivors? What are the best treatment protocols?

Looking contextually, what is the impact on elderly women of a lifetime spent in patriarchal, hierarchical, and often frankly hegemonic settings? How do these aspects of our culture interact with a history of child sexual abuse and manifest themselves in institutionalized elderly? How also does a history of domestic abuse by a battering partner or rape interact with the social context and the experience of institutionalization?

Finally, most of the questions we asked above about women should be asked as well about male survivors of child sexual abuse in institutional settings. What is the impact of institutionalization on male victims of child sexual abuse? While elderly men in general are more likely than elderly women to be abused or victimized (Kosberg & Kaye, 1997), what is the impact of prior abuse on those risks, the resulting symptoms, and their reactivation in institutional settings? With autonomy and control as the purported goals of male development (Bergman, 1991), does loss of autonomy and control have special meaning for men who, during child sexual abuse, were similarly deprived of autonomy and control?

**CONCLUSION: “A BLOW UPON A BRUISE”**

Borrowing Evelyn Waugh’s eloquent chapter title (1946/1979) as our heading, we close by arguing that revictimization and reexperiencing
tends to have an exponential rather than additive effect on the re-abused survivor. Anecdotal and empirical evidence indicate that prior victimization “exacerbates the symptoms associated with post-traumatic stress in the wake of ” revictimization (Boney-McCoy & Finkelhor, 1995, p. 1415; see also Bryer, Nelson, Miller, & Krol, 1987). Thus, maltreatment in the institution may have what appears to be a disproportional impact on women who have a history of childhood victimization. As a result, while many of the “injuries” discussed throughout this article may individually appear slight or even trivial, to the survivor of childhood trauma they may reverberate painfully, like a blow upon a bruise, creating a response that often “seems off.” Indeed such a response is out of proportion until we know and understand the often well-hidden bruises of childhood. We can appreciate the survivor’s response if we remember that most children being sexually abused live “in an environment that is devoid of care, safety, and affection, but is filled with fear, [physical abuse], loneliness, confusion, and distrust” (Fleming, Mullen, & Bammer, 1996, p. 56). To the extent that our institutional practices, intentionally or not, reproduce any of those characteristics, we are likely to be delivering “a blow upon a bruise.”

At the same time, when the history of child sexual abuse is recognized and treated appropriately, five of the six case reports reviewed for this article report dramatic improvement. Aside from the one case in which the woman dropped out of treatment, in all others significant gains in the quality of life and decreases in symptoms were noted, usually within a few months. Thus the literature, though still anecdotal in nature, indicates that when we are willing and able to recognize and treat child sexual abuse in elderly women we are able to avert the blow upon the bruise and contribute to significant healing.

NOTE

1. In this article we focus exclusively on elderly female survivors of child sexual abuse. This focus is in no way meant to minimize either the extent or significance of sexual abuse of males. Our limited focus results from the scarcity of literature on older male child sexual abuse survivors and our clinical impression that aged male survivors are likely to manifest somewhat different symptom profiles. It is our hope that others will extend the analysis presented in this article to older male survivors. Similarly, we do not address the effects of rape or domestic violence experienced during adulthood. Here again, our limited focus is not meant to trivialize the nature or extent of these forms of interpersonal abuse. Instead, we suspect that the effects and manifestations of these forms of abuse may be different and need to be explored in future research and writing.
REFERENCES


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