

SEVENTY YEARS OF MISTRUST: ELDERLY SURVIVORS OF SEXUAL ABUSE

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As a pediatric social worker in a large suburban hospital, designated as a Child Abuse Diagnostic Center, the author was no stranger to dealing with sexual abuse. However, her view of the issue was changed in later years after developing expertise as a Gerontological Social Worker. It was then that the long-term effects of child sexual abuse truly came to light as she dealt with three mature women who had been sexually abused in childhood. These women had been raised during an era when public intervention was non-existent. This article presents their stories.

I have been working with the elderly in some fashion since age 19. My current work in gerontological practice brought me in contact with a 63-year-old woman who, after several sessions, revealed that she might have been sexually abused in childhood. This revelation led me to recall the fact that I had previously dealt with childhood sexual abuse in elderly clients. In fact, two more cases in particular came to mind. I had written and published in this area, however, never regarding the impact of abuse on older adults.

My first job as an MSW social worker, twenty-five years ago, was as a pediatric social worker in a medical center that served as a Child Abuse Diagnostic Center. It was a rude awakening to deal with perpetrators who sexually abused children as young as two months old. Although much has been said of late regarding child protection workers, my hat continues to go off to those who are challenged with the job of protecting society's vulnerable children.

Recently, in my work as a private practitioner and geriatric social worker, my "tables have been turned" as I worked with women over 60 who had experienced sexual abuse in childhood. Their stories reflect an era far different from the one I worked in as a new MSW. I began to investigate the consequences for mature women who had survived sexual abuse in their childhood years.

The literature was appallingly scarce and practice recommendations scarcer still.

Incest has been defined as sexual seduction, molestation, and/or rape of a child by an older relative or trusted friend of the family, or any kind of exploitative sexual contact or attempted contact between relatives, no matter how distant, when the child is under the age of 18. Generally, in defining the concept of incest, it is important to remember that incest is always an infringement upon the rights of the child, and many adult survivors of incest do not recognize this power differential and often blame themselves for what has taken place (Dziegielewski, & Resnick, 1996).

The Case of Mrs. "M."

Mrs. M. was a wheelchair-bound, 80-year-old, divorced female admitted to an assisted living residence when her three sons could no longer care for her in her home. She was diagnosed with Impulse Control Disorder-NOS due to frequent, angry outbursts and occasional physical violence (hitting and punching) towards staff and other residents. She was incontinent of urine and occasionally incontinent of feces. Her sons described her as an angry, difficult woman; nevertheless they remained close to her and were involved throughout the process of her care.

I was first called in to evaluate Mrs. M. due to her angry outbursts and inability to cooperate with staff. The Director of Nursing was particularly concerned about Mrs. M.'s incontinence and refusal to let staff bathe and clean her, regardless of the fact that she was unable to maintain her own hygiene unassisted.

After several sessions, Mrs. M. revealed to me that her inability to accept help with personal hygiene, especially as it related to the washing of her "private parts," stemmed from having been sexually abused by her father in childhood. She stated she did not want anyone touching her and would wash what she could by herself. She indicated that when staff was hurried during her baths, it resulted in physical pain for her. I explained to Mrs. M. that women who were sexually abused as children are often 'at war with their bodies' (Blume, 1990). Touch, any touch, is frequently misinterpreted and reenacts earlier violations. Women such as herself often avoid nakedness at all costs, avoid the use of public bathrooms, shower in their clothes, or avoid showering and bathing altogether. Mrs. M. could relate to these experiences and stated for the first time in her life that she did not feel alone. When she was young, she was unable to talk about the abuse and Mrs. M. believed that the abuse was somehow her own fault.

I asked Mrs. M. if I could alert the Director of Nursing as to her history (to enable her to better direct her staff without revealing Mrs. M.'s secret) and Mrs. M. agreed. Over the next few months, Mrs. M. was able to describe some of the childhood sexual abuse and ventilate enormous amounts of anger at the perpetrator. Since writing was difficult for her, I instructed her to compose mental letters to her father (long deceased) vocalizing her feelings about the abuse. She was able to scream out her sense of betrayal at him and at her mother, whom she felt did not protect her. Over time, Mrs. M. was able to establish a good working relationship with one aide in

particular, a young, soft-spoken, gentle, immigrant woman.

The impact of Mrs. M.'s sexual abuse resulted in nursing care problems in a facility setting. Due to the nature of her illnesses and loss of mobility, Mrs. M. was institutionalized, compromising her ability to protect her own body from invasion. "For the incest survivor, to whom privacy is a primary need ... this already concealed act often requires absolute seclusion or a place that is totally within her control, her own space, her own home ... using the bathroom is ... fraught with risk and the danger of invasion." (Blume, 1990, pp. 199) Blume (1990) also addresses the anger of the incest survivor: "At the other end of the continuum is the incest survivor who is angry all the time ... she may react especially strongly to current violations of her boundaries, perceived or actual" (Blume, 1990 pp. 134-135). Mrs. M. reacted to violations of her boundaries to the degree she was able (lashing out by punching and hitting staff and residents) in a setting which is far more public than one's own home where she did not feel safe revealing her childhood secret.

I spent years working in care facilities for the aged. I presented In-Service education to staff, professionals, and students. I believed I understood how difficult it was to reside in a facility, to live in a place one calls "home," that is not home but is clearly an institution. The daily struggle of being intimately touched by others whose touch was not loving engulfed me. In my life, touch was frequently loving and was always at least empathetic and caring. With all of my training, with all of my experience, with the expertise I knew I had, I neglected to really comprehend the impact of violation. Mrs. M.'s story (as well as those that follow in this writing) forced me to search my soul and all its humanity in an attempt to understand the plight of these women beyond the professional sight by which I had seen them.

Mrs. M.'s loss of control was more than a loss of habitat, a loss of independence, and a loss of functioning. Her loss was a loss of a necessary defense mechanism, control of her memories. In a public setting, she could no longer block the painful reoccurrences of her abuse. My job was to help her differentiate these current experiences from the past. I was also able to demonstrate to her, through my caring, that she was lovable. In accepting my empathetic response to her, she opened herself up to the warmth and caring of others.

The Case of Mrs. "S."

Mrs. S. was a 79-year-old widow, diagnosed with major depressive disorder: moderate and recurrent. She resided with her granddaughter, her granddaughter's husband, and their four children. Mrs. S. married at age 16 and, due to gynecological problems, was unable to have children. She adopted three girls and spent her energies raising them. She never developed a close relationship with her spouse and stated he was an angry, abusive man.

Mrs. S. stated she had been depressed as far back as she could remember. Week after week she remained tearful, hopeless, and helpless. She suffered from severely damaged self-esteem that was never fully repaired. Her childhood sexual abuse was first relayed through the description of her nightmares: recurrent dreams in which she was being chased by a tiger. She would wake in a panic and stated she was generally bathed in a cold sweat. Over time, Mrs. S. revealed that at four years of age, she remembered being lured into the basement by her stepfather and afterwards received a beautiful new pair of Mary Jane shoes. During our sessions, Mrs. S. repeatedly stated, "Nothing in life is free."

Mrs. S. also revealed that when she finally divulged the abuse to her mother, she was ostracized and forced to leave. This resulted in an early marriage and a final "escape from my stepfather." Dreams played a pivotal role

in the world of Mrs. S. She relayed having dreams of her dead mother beckoning her to come to her. She stated that her sister had also been sexually abused as a child and that recently both had revealed the details of that abuse to one another.

Because Mrs. S. was unable to become pregnant, she was never certain as to whether or not her gynecological problems were a result of the abuse. I worked with Mrs. S. for three years, and developing trust was enormously difficult for her. Throughout my work with Mrs. S. the probability that her inability to bear children was most likely tied to her abuse as a four-year-old child plagued me. I couldn't help but dwell upon human fragility, particularly fragility of the body. Mrs. S.'s dreams of giving birth were shattered through the early violation of her body, yet she made the children of others her own, adopting her three daughters.

This experience helped me enormously in coming to terms with the weakness of the body in juxtaposition to the strength of both the mind and the soul. I now use this growth experience in my own work with the physically ill, frail, and dying and teach my students to find strengths even in the seemingly weak. I encourage them to help their own aged, ill, and/or dying clients recognize that where the body may be vulnerable, the spirit and will are often strong. I currently teach in a sectarian university and incorporate faith, the spiritual, and the religious into my practice, my teaching, and my personal life when appropriate and possible. Unfortunately, such insights often evade youth. Early in my social work career, I covered the critical care unit of a hospital in a residential beach community. During my first summer there, four young men were admitted into critical care after sustaining spinal cord injuries. I was young, they were young, and none of us could focus on strengths worthy of development beyond the physical. Working with elderly, abused women reinforced for me that who we are transcends what we are.

Armed with this insight I have learned to focus more on thoughts, feelings, past accomplishments, and contributions, rather than on the loss of capacities, frail physicality, recent dependencies, and losses when I work with the aged population.

The Case of Ms. C.

I am currently working with Ms. C., a 63-year-old, single woman who presents with low self-esteem and episodes of extreme anxiety. We have been working on issues of decreasing her anxiety as well as increasing good feelings about herself and her capabilities. Ms. C. states she believes she was sexually abused as a child, and she thinks the perpetrator was her maternal grandfather. Ms. C. is a very talented woman who was a teacher for many years and is an artist and a poet. Her paintings are beautiful, serene depictions of animals and nature. Her poems are simple yet powerful and create soft, gentle images.

I hesitated telling Ms. C. about the writing of this article. Finally, I decided to throw caution to the wind and stated I wanted her permission to tell her story. Not only did she excitedly tell me "of course," she asked if she could write her story for me. In this simple conversation, Ms. C. reminded me that we do not heal others; we provide the means for them to heal themselves. The following is Ms. C.'s story, related in her own words:

"When I was a young child I believe that I was sexually molested by my grandfather. I had this memory that I heard the crackling of the furnace in the basement when I was molested. Later, I would have nightmares of a bear chasing me, so I locked the doors and he couldn't come in. There was a man in the house around the same time standing by the china closet. He was able to take his teeth out of his mouth. That

frightened me and I moved away from him. Another night, there was a nightmare...when I walked down the stairs into the cellar; hundreds of huge spiders fell on me. I struggled and they fell off.

A nightmare that followed me into adulthood is one where the gnashing of teeth comes out of a face with a smirky look. One of my strong nightmares involved being in the presence of coffins and corpses. It never failed that the corpse would get out of the coffin looking for me, and chasing me around the room. I did not want to touch him. One day, when I was complaining about my nightmare, my priest told me to touch that disgusting sight and I did. The corpse disappeared. Corpses no longer chase me. I still dream of them but they stay in their coffins.

One time I dreamt of my grandfather in a coffin but he didn't get up and chase me. I remember he was an alcoholic and used to hit my grandmother. My sister once asked me if we were ever abused, I said yes. 'Was it our dad?' she asked? 'No,' I told her, it was our grandfather.' She ended the conversation."

Ms. C. and I have been working on allowing the grown woman in her to protect the vulnerable child and for the grown woman to recognize her talents, worth, and power. I respect her right to deal with the issues of childhood sexual abuse to whatever degree she finds comfortable. McInnis-Dittrich (1996) addresses the need to "respect the client's right to refuse therapy" when childhood sexual abuse has occurred (p. 172). "True empowerment for these older women may lie in therapists respecting their conscious

choice not to revisit the abuse" (McInnis-Dittrich, 1996, p 171).

Time does not heal the impact of child sexual abuse, and the effects appear to be life-long in nature and may require the development of specific services for this population (Allers & Benjack, 1992; Blume, 1990). Walter (1992) talks about several elderly survivors of sexual abuse with whom she has worked, all of whom exhibited anxiety and depression. "Our societal stereotype of the elderly as unlovable, unattractive and bothersome does nothing for an elder's waning self-esteem. Additionally, in an effort to preserve self-esteem, society encourages the elderly to see themselves in terms of who they have been. Unfortunately for the elderly survivors of incest, this includes being a victim" (Walter, 1992, p. 15). Survivors must be reminded that they have indeed survived as a result of inner strength and fortitude. They must also be reminded that who they were is not who they are.

These older women have lived full lives that have taken them way beyond their abuse. We all grow past our experiences of youth despite the fact that those experiences are incorporated into who we are. I am reminded by these women and their stories that living is perhaps our greatest teacher and that I too continue to learn, grow, and develop regardless of my many years of experience. I dedicate this article to women everywhere who have had the courage to survive sexual abuse in childhood, and hope that those who struggle continues will find a way to rise above.

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