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# Effects of Incest in Aging Survivors: Psychopathology and Treatment Issues

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*Most older people who have been sexually abused in childhood have probably never been treated for the consequences of their destructive experiences. The character pathology and long-term effects of child sexual abuse are described. Parallels were drawn between delayed Posttraumatic Stress Disorder seen in older veterans and World War II victims and later-life onset of posttraumatic psychopathology in aging incest survivors. Special geropsychological treatment issues, such as the appropriateness of explicit inquiry regarding a history of abuse and the role of power, gender, and shame in the psychotherapeutic relationship, are presented. The dilemma of uncovering repressed malignant childhood trauma in aging individuals is discussed. With proper medical and psychological preparation, demanding curative interventions with older survivors may be considered.*

**KEY WORDS:** aging; psychotherapy; incest survivor.

## INTRODUCTION

In recent decades, the mental health and social welfare fields have undergone a revolution in professional recognition of the role of child abuse in the development of psychopathology. Nevertheless, long-cherished clinical "truths" about the etiology and treatment of several adult psychological problems and disorders are only reluctantly being revised despite disconfirming research data. Regardless of specific type of maltreatment, the sequelae of child abuse are likely to occur in at least three stages (Briere, 1992a): (1) initial reactions to victimization involving acute posttraumatic symptomology; (2) accommodation to ongoing abuse, involving coping behaviors intended to increase safety and/or decrease pain during victimization; (3) long-term elaboration and secondary accommodation reflecting deep-seated alterations and distortion of the developing personality.

Given our current knowledge of the prevalence of child sexual abuse, geropsychological evaluations should also include assessment modules for the collection of data on trauma-related symptomatology.

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## LONG-TERM EFFECTS OF CHILDHOOD SEXUAL ABUSE

The empirical and clinical literature on the long-term impact of childhood sexual abuse (CSA) provides ample evidence on the harmful long-lasting effects for many individuals. More than one half of the sexually abused children seem to meet the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM) criteria for Posttraumatic Stress Disorder (PTSD; McLeer *et al*., 1988). Untreated, many of these hurt children develop into hurt adults. In a community sample of 930 women, Russell (1986) found that 78% of those who had been abused reported long-term negative effects of the abuse experience. Many adult survivors of childhood sexual victimization report intru sive reexperiencing of the trauma (Rowan *et al*., 1994). These periods of reliving the abuse can produce a temporary break with the current environment, resulting in what may be misinterpreted as a psychotic breakdown (Gelinas, 1983). In some case, such apparent confusion and disorientation could be erroneously diagnosed as dementia. In many adult survivors, chronic autonomic hyperarousal may produce various somatic difficulties such as headaches, hypertension, back pain, and gastrointestinal problems (Briere, 1992b) or sleep disturbances (Sedney and Brooks, 1984). These problems could be mistaken for other common health concerns that older individuals tend to complain about.

Survivors CSA have been afflicted by attenuated feelings and emotions and detachment from both the hurt self and from others (Meiselman, 1990). These phenomena represent dissociative coping tactics typically developed during the victimization process in an attempt to avoid inescapable fear, arousal, pain, and humiliation. Dissociative defenses can also lead to a cognitive disengagement from the environment, contributing to a sense of "spacing out," forgetfulness, and confusion. Memory disturbances are also common among survivors of sexual abuse (Feldman-Summers and Pope, 1994; Loftus *et al*., 1994) and are reflected primarily in impaired recall of childhood events.

To provide an appropriate treatment module, the geropsychologist encountering memory impairments has to ascertain that the memory loss is not better accounted for by dissociation, a concept discussed later.

## CHARACTER PATHOLOGY DUE TO ADAPTATION TO VICTIMIZATION

Childhood responses to repeated, overwhelming trauma inflicted by caretakers create meta-effects that reflect the interruption of normal childhood development and the elaboration and generalization of maladaptive schemes about the self and others. Adult survivors of prolonged childhood trauma are hypervigilant. They constantly monitor others in order to avoid a painful outcome. Briere (1996) called this core effect "other directedness," and claimed that this personality pattern may allow the adult survivor either to "(a) avoid or forestall an abuse incident by escaping in some manner, or (b) placate or fulfill the abuser's needs before more aversive consequences ensue" (p. 53). Other adult survivors of CSA perceive the world with bitter cynicism as a hostile environment and define their relatedness to others in terms of control or power. Chronic victimization of children is frequently accompanied by verbal stigmatization by the abusing caretakers. This attitude is often internalized and frequently develops into active self-loathing.

This kind of self-directed hate and disgust often results in failure to engage in self-care behaviors. Individuals who feel so negatively about their bodies or selves may intentionally

avoid seeking medical care when needed, may actively deny prescribed diets or medical regimen, or may actively engage in self-abusive behaviors.

Byrne (1961) developed a personality theory that divides most people into "sensitizers" and "represssors." These divergent personality styles are also represented among the core personality effects of severe child abuse. Some survivors are hypervigilant to danger, but others attempt to meet potential danger with a diminished awareness of environmental risk, or even of the horror of any current torment. This kind of denial in adult survivors can lead to increased gullibility and to proneness to revictimization. Child maltreatment disrupts the normal development of self-functions (Friedrich, 1993).

This may mean that aging adults abused as children may have a poor sense of their personal identity and, in the face of environmental challenges, they may become less organized, more fragmented, and less aware of their own entitlements. These individuals are also less aware of the demarcations between their perspectives and those of others, and so are at higher risk of intrusions or transgressions, in turn, exposing them to further danger of abuse and exploitation.

The prevalence of CSA seems to be high. When defined as sexual contact, ranging from fondling to intercourse, between a child in midadolescence or younger and a person at least 5 years older, sexual victimization reaches 20% to 30% for females (Finkelhor *et al*., 1989) and up to 20% for males (Henschel *et al*., 1990). Although the mental health field has been much more aware of the prevalence of these traumata and their impact on the mental health of survivors, it is conceivable that many aging survivors were never correctly diagnosed and so may continue to suffer from the adverse chronic core effects of the traumata they sustained many decades ago in childhood.

## PSYCHOTHERAPY WITH THE AGING PATIENT

The number of older adults in the population has grown dramatically. In 1900, only 4% of people living in the United States were older than 65. By 1990, 13.5% of Americans were older than 65 years, with that figure projected to increase to as high as 17% by the year 2010 (Treas, 1995). Growing populations of older adults who are healthier and better educated than previous cohorts are to be expected. Presumably, they will be more psychologically minded than the older adults of earlier cohorts and therefore more open to psychotherapy. Because of women's greater life expectancies, communities of older people are predominantly female, and clinicians interested in working with aging clients should be aware of gender-related issues, such as the higher likelihood of sexual victimization histories among females. Despite agist pessimism about the ability of older adults to benefit from psychotherapy, the literature suggests that these clients improve when given appropriate treatment (Gallagher-Thompson and Thompson, 1996; Qualls, 1996; Smyer *et al*., 1990).

The frequently presented psychological problems of this population are likely to include depression, anxiety, and adjustment disorders. These problems often interact with physical frailty and medical problems (Zarit and Knight, 1996). Loss is a common theme presented by the aging client. Other typical issues include grieving for loved ones, for lost health and mobility, and for lost or missed opportunities. The internal auditing process in which many older patients engage in is probably related to the increased tendency to turn inward and to become more reflective, a developmental process also known as interiority (Neugarten, 1977).

## EARLY-AGE TRAUMA AND OLDER ADULTS

Patients who survived early-age traumatic stress have emotional memories that are laid down without a narrative. Traumatic memory is mostly stored in what is known as a "hot" memory system with the amygdala as its centerpiece. The amygdala-based system is critical for the conditioning and retention of emotion itself, and its activity increases during stress (LeDoux, 1992, 1993). The "cool" memory system with the hippocampus as its centerpiece is critical for the conditioning and retention of spatiotemporal context. The activity in this memory system dramatically diminishes under stress (Thomas *et al*., 1995). This means that under traumatic stress, emotional memories are laid down without a significant contribution from the hippocampal system. Later-life experiences, such as loss of autonomy, can operate as retrieval cues for traumatic memories. However, without the hippocampal input, these memories are frequently experienced as disorganized, distressed affect rather than memorial events with a beginning, end, and internal spatiotemporal structure. The only clue for therapist and patient that these might be "hot" system memories is their conditional emergence in response to specific environmental cues.

Clinical observations teach us that single traumatic experiences, such as an isolated rape, might also result in a trauma-induced amnesia. However, single traumatic experiences are more likely to be recovered later on as a narrative memory, triggered by later-life cases.

Most studies on early-age trauma in aging survivors relate to World War II veterans and Holocaust survivors. The war neuroses of World War II provided ample evidence that repression of trauma did indeed occur, and that later recovery of these traumatic memories in veterans and survivors led to remission of symptoms (Karon and Widener, 1997). Several case reports appeared in the literature on PTSD with delayed onset. According to the DSM-IV (American Psychiatric Association, 1994), this specification for PTSD is given if onset of symptoms is at least 6 months after the stressor.

Christenson *et al*. (1981) described a 55-year-old veteran who developed PTSD after being exposed to a traumatic sight that invoked guilt-ridden memories of a World War II incident in which he shot a 10-year-old boy. Hamilton (1982) described a 55-year-old veteran who was admitted with amnesia of an extremely aggressive attack in which he was physically and verbally violent toward his pregnant girlfriend. Discussion on whether to abort the pregnancy triggered repressed memories of senseless deaths of a woman and child during World War II. Van Dyke *et al*. (1985) reported on a 61-year-old Dutch veteran who for the first time after more than 30 years uncovered frightening memories of World War II. Other examples of reactivated wartime traumata in older veterans have been described by Kline and Rausch (1983), Richmond and Beck (1986), and Brockway (1988). Many of these clinical reports suggested that age-associated losses, such as death of loved ones, decline in health, or retirement, can trigger feelings of lack of control and reactivate symbolically similar repressed traumata.

The difficulties in working through early trauma in psychotherapy with older survivors are also related to the phenomenon of alexithymia. This concept has been used to characterize the affective impairment in Holocaust survivors (Krystal, 1988a,b). Because of their difficulty in identifying emotions, alexithymic individuals express their psychological problems in concrete ways such as somatization (Nemiah and Sifneos, 1970). In a recent study, 56 survivors of Nazi concentration camps, ages 52 to 79, were studied. Alexithymia in these individuals was associated with severity of PTSD symptoms (Yehuda *et al*., 1997).

Another concept associated with numbing and repression of traumatic memories is dissociation. This is a mental process that produces a lack of connection in a person's thoughts, memories, feelings, actions, or sense of identity. During a traumatic experience, a person may dissociate the memory of the place and circumstances of the trauma from his or her ongoing memory, resulting in a temporary mental escape from the fear and pain of the trauma and, in some cases, a memory gap surrounding the experience. The prevalence of stressful events among patients with dissociative disorders is unusually high (Irwin, 1994; Kirby *et al*., 1993). Connections between early trauma and dissociation in older survivors has been established. Sixty elderly Holocaust survivors with and without PTSD were evaluated by the Dissociative Experiences Scale. The aging survivors with PTSD showed significantly higher levels of current dissociative experiences than did the control group (Yehuda *et al*., 1996). Dissociative amnesia of early trauma was demonstrated in two case studies on older survivors of the Holocaust. In one report, the author concluded that dissociation in these cases is a defense that is best not removed (Modai, 1994); in the other, the aging survivor was hypnotized and abreacted so that she could work through her dissociated traumatic grief (Somer, 1994). It appears, however, that certain types of traumatic events are more likely to induce long-lasting dissociation than others. Dissociation is thought to be particularly present in persons who were sexually abused as children (Chu and Dill, 1990; Terr, 1991). Dissociative amnesia can work well for many incest survivors. However, as Lipton and Schaffer (1986) have postulated, age appears to weaken previously adequate defenses.

## TREATMENT ISSUES IN AGING INCEST SURVIVORS

### Asking About Incest

Older women who were sexually abused as children may lack conscious awareness of the abuse and typically may seek therapy for a seemingly unrelated problem (e.g., depression). Their symptomatology would compromise their functioning and their quality of life. Many therapists who work with older patients may be reluctant to ask about a history of abuse. Natural respect for older adults, projection of our own discomfort in talking about sex with a parental figure, and a belief that patients will divulge sensitive aspects of their histories when they are ready can all contribute to a tendency to avoid a direct exploration of the issue.

Given our own countertransference resistance to knowing that the older patient sitting before us was violated sexually as a child, given what we now know about the prevalence of CSA, and given the secrecy usually surrounding an adult survivor's childhood victimization, we are obliged to explicitly and routinely ask about such experiences. Many older women who had had multiple unsuccessful psychotherapies during their lives, never disclosed their abusive histories (Cole, 1988). Asking often facilitates disclosure, and disclosure is necessary for healing to occur.

### Shame and Self-Blame

Persons who have been sexually abused in their families carry within them a deep sense of shame and self-blame. Many of the older survivors feel alienated from others and believe that anyone can look at their faces and their bodies and know "how dirty they are."

These patients frequently avoid eye contact and hide their bodies in oversized clothing. Sgroi (1982) used the term "damaged goods syndrome" to describe how sexually abused persons experience themselves. A number of older survivors will have tried to resolve their intolerable feelings of bodily loathing by regarding their body as a transitional object that can be neglected or even abused. These older patients will tend to ignore signs of deteriorating health, but in some instances will actively mutilate their breasts and vagina or injure visible parts of their skin to publicly profess their shame and wear it like a "mark of Cain." These patients frequently harbor a deep-seated belief that the incest was somehow their fault. The guilt that ensues is a feeling that surfaces from the experience of having done something very bad. The need to preserve the parental objects as good contributes to the internalized sense of being uniquely bad. According to Fisher (1985), these dynamics produce shame. Adjunct group therapy for survivors of CSA could help many older patients to develop a first sense of belonging. Group therapy can help the aging survivors to realize that their shame and self-blame are not unique to them, but a common distressing symptom that many victims experience. This realization can also help them to challenge this distorted attribution of responsibility. In principle, abuse-oriented psychotherapy assumes what to many is intuitively obvious: children have less power than adults, are dependent on them, and are intellectually incapable of free and informed consent to have sex with them.

## Power Dynamics

When the patient is aging and the therapist is a younger male, it is likely that the therapist might be the same sex as and of an age similar to that of the perpetrator. The aging female survivor is less likely to try to exert control over the threatening relationship with the younger male therapist, using the same ways she used when she was younger: using sexual or stereotypical feminine behaviors to barter for acceptance and validation. Some older female survivors will present as hostile and disdainful of their male therapist. Because of their loathing of their own sex, some older incest survivors will be drawn to a sado-masochistic reenactment with a younger male therapist. Although such transferential process could be utilized in therapy, many authors in the field of incest trauma therapy suggest that a female therapist is advantageous (Alpert and Paulson 1990; Herman, 1981). A mature female therapist might elicit less defensiveness from the older incest survivor, may be more aware of central women's issues, and may be more nurturing and empathic. A combination of empowering feminist-oriented therapy and trauma-focused psychodynamic therapy appears to be a successful approach to healing.

## Risks of "Teasing the Dragon"

Working with delayed PTSD frequently means that the uncovering process might destabilize the patient. Many incest survivors who have had amnesia for their abuse suffer a treatment-related subjective deterioration during their treatment. The uncovering process of long-avoided memories means a resurgence of distress that is commensurate with the gradual abdication of dissociative defenses. With older patients, their toleration for the stressors associated with trauma-focused therapy must be considered. Older patients who have recently endured a major change in their lives or a loss and patients who are physically

frail or lack a reasonable support system should be considered for supportive and ego-strengthening therapy first. The course of trauma-processing therapy with the aging must be titrated against the patient's available external resources and against his or her ego strength.

## Medical Preparation

Psychological stress can have direct effects on physical health. Alterations of cardiovascular reactivity and the immune system are well-documented consequences of psychological stress (Haley, 1996). Such changes have been linked with the onset and course of respiratory infections, cancer, and hypertension (Adler and Matthews, 1994).

Trauma clinicians working with aging survivors should have their patients physically examined as part of the evaluation process. For example, a hypertensive older survivor of Auschwitz was considered for hypnotic exploration of repressed traumatic material. Her physician was consulted about her capacity to withstand the potential stress that the traumatic repressed material might elicit if tapped. The physician cautioned against extreme emotional arousal and decided to prophylactically increase the dosage of her beta-blockers, and as an additional protective measure also prescribed a benzodiazepine. The physician, who supported the hypnoanalytic intervention, further collaborated by scheduling the patient for weekly blood-pressure monitoring throughout that psychological procedure (Somer, 1994).

## Self-Efficacy and Temporized Exposure

Successful therapy with aging incest survivors should emphasize the achievement of mastery through a cooperative therapeutic alliance. Many of these patients suffered traumatic exploitation that rendered them helpless and without hope. A controlled benevolent joint exploration of the perilous childhood can be a curative process. Before embarking on the exploration of threatening material, patients should be taught relaxation and stress management techniques. Exposure to the long-avoided materials should be gradual. The patients can be taught to utilize their own dissociative defenses as affect-regulating mechanisms. Kluft (1988), in his work with aging patients suffering from severe posttraumatic dissociative disorders, suggested the "slow-leak" technique. In this intervention, the therapist suggests hypnotically to the patient that his or her toxic feelings should be deliberately allowed to leak in minuscule droplets at a rate that will cause no risk to the survivor. Fine (1991) proposed to help the survivor uncover the encapsulated trauma in small increments. In a desensitizing way, feelings can be slowly reconnected to discrete aspects of the newly uncovered history of the survivor.

## SUMMARY

This paper describes the long-term and delayed effects of childhood sexual victimization. Most older patients molested as children were presumed not to have received appropriate therapy at the time, and that for many of them the childhood experiences were

so damaging that they continue to be affected as older adults. Some manage to compartmentalize the destructive memories for decades. Others may suffer from delayed PTSD and encounter the first distressing symptoms only in later life. This article described significant treatment issues and approaches that need to be considered when working with the aging survivor of incest. Like the survivor, the therapist should be concerned with balancing confrontive and uncovering techniques with the need to protect the potentially frail health of the aging patient. Geriatric psychotherapists must be sensitive to potential child abuse factors that may influence or perhaps account for the magnitude and patterns of unremitting non-organic geriatric psychopathology.

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