Elder Sexual Abuse

PowerPoint Presentation
What is Elder Sexual Abuse?

Elder sexual abuse is defined as coercing an older person through force, trickery, threats or other means into unwanted sexual activity.

It includes sexual contact with elders who are unable to grant consent, and sexual contact between service providers and their elderly clients.

Talking Points:
• A working definition of elder sexual abuse.
Elder Sexual Abuse can include:

- the offender forcing the victim to view pornography or to listen to explicit sexual accounts or comments
- coerced nudity and sexually explicit photographing
- sexualized kissing and fondling
- oral-genital contact/digital penetration
- vaginal rape/anal rape
- rape by objects/attacking victim’s genitals with blows or weapons

Talking Points:

• Sexual violence is made up of a continuum including rape, incest, ritual abuse, marital or partner rape, sexual exploitation, unwanted sexual contact, sexual harassment, exposure and voyeurism.
How is Sexual Abuse Different for Elders?

- Lack of a support system
- Generational beliefs about sexual abuse
  - Rigid gender roles
  - Anything sexual should not be discussed
  - Domestic or child sexual abuse was not recognized
- Exacerbation of existing illnesses
- Longer recovery times

Talking Points:

- **Bullet 1:** As an individual ages, his or her support system may begin to weaken—for example, physical disabilities limit a person’s mobility, lack of employment limit social interaction or peers may begin to die.

- **Bullet 2:** Elders may still hold generational beliefs, such as:
  - Women were not supposed to have sex before marriage, and were labeled immoral by family and peers if they did. Men, on the other hand, were seen as hormonally-charged individuals who always thought about and wanted sex. It was a good girl’s duty to deny the uncontrollable libido of boys.
  - Mothers and fathers did not discuss sex with children, and children did not discuss sex with their parents.
  - If marital rape occurred, it was the husband’s right in marriage. Childhood sexual assault was not recognized, especially within the family or by influential members of society such as teachers or clergy.

- **Bullet 3:** If an older victim is suffering from an illness, emotional and/or physical responses to sexual abuse such as depression may worsen the current illness.

- **Bullet 4:** For the above reasons, elder victims are more likely to internalize the abuse and not seek treatment—lengthening and intensifying the reaction to sexual abuse causing longer recovery times.
How is Sexual Abuse Different for Elders?

- Increased chance of sustaining serious injury
- Increased vaginal or anal tearing and bruising that may never fully heal
- Brittle pelvis or hip bones can be broken by friction or weight
- Increased risk of infections
- STDs

Talking Points:

- **Bullet 1 and 2**: Elder victims are more likely to experience genital injury—along with an increased risk of that injury requiring surgical repair.
- **Bullet 3**: As people age, their bones become more brittle and weak. Force is more likely to break or fracture bones.
- **Bullet 4**: Due to the increased risk of tearing and lack of medical attention, the risk of infection increases for elder sexual abuse victims.
- **Bullet 5**: An elder victim is unlikely report sexual abuse, especially immediately after the abuse when treatment for STDs is most important. Even if the abuse is reported, treatment for injury and STDs may not be provided.
Institutional Sexual Violence

- A more regulated environment—mandatory reporting laws, protective services, Department of Health licensing, ombudsman programs
- Contact with other residents
- Contact with long-term care facility staff

Domestic Sexual Violence

- Limited contact with others
- Family violence

Talking Points:

Institutional Sexual Violence: (Only 4.5 percent of 65+ population are in long term care facilities.)

**Bullet 1:** Mandatory reporting may bring perpetrators to light and/or prevent sexual abuse.

**Bullet 2:** Other residents may serve as a support system, but also may be perpetrators. Dementia, Alzheimer’s and other cognitive diseases can lead to violent behavior.

**Bullet 3:** A staff member may serve as a support system or may be a perpetrator. Many facilities have a high turnover rates and shortage of workers.

Domestic Sexual Violence

**Bullet 1:** Elders partially and fully dependent on a caregiver — either a family member or friend or a home health worker—can be vulnerable to abuse due to the likelihood of limited contact with others and physical dependence. Independently functioning elders residing in their home may be sexually abused as people of any age are—by a stranger or acquaintance—but factors like living alone, isolation and the perception of old age increase vulnerability.

**Bullet 2:** A women’s son could take on his father’s abusive role or a family member may use a caregiver role to become abusive.
Talking Points:

• Refer participants to the final handout of the Power and Control Elder Abuse Wheel, which illustrates the range of elder abuse.

• Generally one offense accompanies others. For example, a sexual abuser can also isolate and threaten the victim.
Elder Sexual Abuse Fact Sheet

Statistics and information from six studies on elder sexual abuse

Talking Points:

- The six studies comprise the published work available on elder sexual abuse from 1990 and on.
- Research on elder sexual assault is just beginning, so studies are smaller and conducted under limiting circumstances.

Instructions: Pass out the fact sheets to each participant and allow about 5 minutes for review.
Elder Sexual Abuse Quiz

Instructions: After review of the Fact Sheet, pass out a copy of the quiz to each participant. Allow about 3–5 minutes for participants to complete the quiz, and then review the answers.
Keep in mind…

■ 129 was the largest sampling of victims

■ No random sampling of the population

Talking Points:
• **Bullet 1:** 129 is not a large enough sample to apply statistics to the general elder population.

• **Bullet 2:** Each case study was gathered under specific circumstances—most used the memory of protective service workers (thus only using reported cases), while others used women from a nursing home sent to a forensic nurse for treatment, or women seeking treatment from a medical doctor or rape crisis center. Some studies used only residential cases, others only nursing home cases.

Although these studies can assist in identifying trends, no study used was a large sampling of the population of men and women age 60 or 65 and older.

Thus, no study offers statistical information that can be applied to the general elder population.
Why Is Elder Sexual Abuse Hidden?

- Government reports/academic research lump sexual abuse into the definition of elder abuse

- Elder sexual abuse is very hard to track because of lack of disclosure and/or reporting

Talking Points:

• This slide explains why elder sexual abuse is not widely recognized or researched.

• **Bullet 1**: The lumping of elder sexual abuse into a larger category makes it difficult to track the prevalence of elder sexual abuse and thus work on prevention and treatment.
  
  • For example: PA’s Older Adult Protective Services Act defines abuse as:
    
    Injury—physical harm, pain or mental anguish.
    
    Neglect—deprivation of necessary goods and services.
    
    Sexual Abuse—as defined by PA law (see Module 5).
  
  • Others lump sexual abuse with physical abuse.

• **Bullet 2**: Elder victims rarely report sexual abuse. Sexual abuse is generally a private crime—only the victim and perpetrator are present. If the victim does not come forward, the perpetrator certainly won’t, and the abuse is not recognized or treated.
Module 3

Activities

Elder Sexual Abuse
Elder Sexual Abuse Research: A Fact Sheet


Study of 52 women age 55+ who sought treatment at the Memphis Sexual Assault Resource Center in Shelby County, Tennessee from January 1987 to September 1990.

- 68.8 was the mean age of the older victims; 40% were white and 60% were black.
- 89% of victims requested services within 24 hours of the assault.
- 9% of victims had experienced a prior sexual assault.
- **72% of assaults occurred in the victim’s home, although 80% of perpetrators were strangers to the victim.**
- 70% of the assault involved penile vaginal penetration.
- 51% of victims sustained genital injury (compared to 13% of victims age 18-45 served during the same time period). 28% required surgical repair.
- **9% reported the assault** (compared to 25% of victims age 18-45 served during the same time period).


Dallas County study of medical and forensic records from 1986-1991 of 129 postmenopausal women (50+) compared to 129 women age 14-49 who reported being sexual assaulted.

- 2.2% of women reporting sexual assault in Dallas County were postmenopausal.
- **43% of postmenopausal victims had genital trauma** (compared to 18% of younger victims).
- 1 in 3 had genital abrasions or edema.
- **1 in 5 had genital lacerations of which 25% were severe enough to require surgical repair.**


1989 survey of elder protective service workers and supervisors at Massachusetts Elder Affairs Conference and Recognition Day who described 28 cases in questionnaire. All victims were female and lived in the community.

- **71% were totally dependent or functioning very poorly or poorly; 43% had psychiatric impairments** (Alzheimer’s, mental retardation, stroke patient, etc.)
- 61% of cases involved rape, others involved fondling, voyeurism, vaginal and anal rape with objects and forced viewing of pornography.
- 1/3 of sexually abusive acts were witnessed by others—family members, home health aides, protective service workers and neighbors.
- 32% disclosed sexual abuse, and 7% alluded to the sexual abuse.
- 96% of perpetrators were male; **81% were the victim’s primary caregiver; 78% were family members (39% were sons) and over 50% of the cases constituted incest.**

In 1992, letters were sent to British health and social services journals requesting professionals with information on specific elder sexual abuse cases to complete a questionnaire. A total of 90 cases were compiled over a 6-month period.

- 85% of victims were female, of which 85% were 75+, 77% suffered from dementia and 78% were widowed.
- 84% of female victims and 93% of male victims were functioning at a poor to very poor level.
- 98% of perpetrators were male, 88% of victims were dependent on the perpetrator for care.
- 55% of all perpetrators were the female victims’ sons, son-in-law (12%), or grandsons (12%). For male victims, 62% were friends and 31% were housekeepers.
- 71% of female victims were vaginally raped and 60% subjected to genital fondling.
- 77% of male victims were anally raped, 69% subjected to threats and emotional abuse and 54% subjected to genital fondling.


Study of 20 sexually abused nursing home residents referred a forensic nurse. The nurse used medical records and treatment of cases to compile data.

- 90% of victims were female, 80% were white, 70% were widowed and 80% were over age 70.
- 60% suffered from dementia; others had cognitive deficits. Many also suffered from cataracts, stroke, hypertension, diabetes, glaucoma and cognitive heart failure. Confusion, loss of long and short-term memory and disorientation also appeared on the victims’ medical records.
- None of the victims reported the sexual abuse to nursing home administration.
- 30% of abuse was observed by either a nursing home employee or another resident.
- Despite prevalent cognitive hindrances, 85% of the perpetrators were identified.
- A rape exam was conducted on only 50% of victims due to delayed reporting, disbelief of the resident’s accusation and failure to follow protocol.
- Of the exams conducted, 60% found some type of evidence. The rape exams were difficult to administer due to resistance to the pelvic exam and difficulty in communicating in general and in obtaining a report of the incident.
- Trauma-related responses included expressions of fear or avoidant behavior towards male staff, withdrawn behavior, staying close to the nurses’ station and lying in bed in the fetal position. Some refused personal care like bathing or medication; others experienced appetite changes and sleep disturbances. Reenactment and sexualized behaviors were also noted. Several demented victims seemed to revert back to a memory of child sexual assault. Although every victim reacted differently, most were easily agitated and anxious.
- Physical signs included bruising, skin tears, vaginal bleeding, prolapsed uterus, urinary tract infections and sexually transmitted diseases.
- 55% of the victims died within one year of the assault.

*From July 1996 to July 2001, data was collected from all Virginia Adult Protective Service units on substantiated cases of elder sexual assault. 80 cases of substantiated sexual assault of adults 60+ were identified.*

- 95% of victims were female, and 81% were between age 70 and 89.
- 72% lived in an institutional setting: a nursing home or assisted living facility.
- 80% were isolated incidents.
- 76% of cases were witnessed by others: 48% by a fellow resident, 32% by facility staff.
- 73% of cases involved kissing and fondling, 43% unwanted sexual interest in the victim’s body, 13% unwanted description or discussion of sexual activity. Digital penetration occurred in 5% of cases and vaginal rape occurred in 5% of cases.
- 98% of perpetrators were male, 53% were between age 70 and 89. 69% were fellow residents, 5% facility staff. 28% had an untreated psychiatric illness and 16% abused alcohol or drugs.
- 5% (4 cases) were prosecuted, of which 3 cases resulted in a conviction and one case resulted in a jail sentence.
- For the 71 cases reported and were not prosecuted, 62% were not prosecuted due to insufficient evidence.
- 72% of the abused older adults were relocated; 27% received some kind of treatment. 11% of victims remained at risk for sexual abuse after the abuse was substantiated.
- 29% of perpetrators were relocated to another facility; 13% received psychiatric treatment. **In 33% of cases, no action involving the perpetrator was taken.**
Elder Sexual Abuse Quiz

*Circle True or False*

1. True   False  The average age of a victim of elder sexual abuse is 65.

2. True   False  The majority of elder sexual abuse victims are men.

3. True   False  Most elder sexual abuse occurs within a nursing home.

4. True   False  The majority of elder sexual abuse victims function independently.

5. True   False  The majority of elder sexual abuse is not witnessed by others.

6. True   False  The majority of elder sexual perpetrators are caregivers.

7. True   False  The majority of elder sexual abuse perpetrators are the victims’ brother.

8. True   False  Elder sexual abuse victims are unlikely to report abuse.

9. True   False  The most common form of elder sexual abuse is vaginal penetration.

10. True   False  An elder victim is less likely to sustain genital injury from a sexual assault than a younger victim.
Answer Key:
1. False. The average age of an elder sexual abuse victim is 65.
The average age of a victim can not be determined from research, but most victims were age 70 and older.

2. False. The majority of elder sexual abuse victims are men.
The majority of victims are female. The fact sheet indicates that at least 85% of victims were women in the cases studied. This is partially because there are more females age 65 and older (The male to female ratio is 70 to 100 over age 65 and the proportion increases as age increases according to the U.S. Census Bureau, Census 2000).

3. True and False. Most elder sexual assault occurs in a nursing home.
Only one study researched all reports of elder sexual assault (Teaster), but it did indicate that 72% of substantiated elder sexual abuse occurred in an institutional setting.

4. False. The majority of elder sexual abuse victims function independently.
The research indicates that the majority of victims were functioning poorly and dependent on others for care.

5. True and False. The majority of elder sexual abuse is not witnessed by others.
Teaster reports 51% of abuse was witnessed, although mostly by fellow residents of long term care facilities, while Ramsey-Klawsnik indicates one third of sexual abuse was witnessed by other in domestic situations.

6. True. The majority of elder sexual perpetrators are caregivers.
The research identified majority of perpetrators as caregivers.

7. False. The majority of elder sexual perpetrators are the victims’ brother.
The majority of perpetrators are the victims’ son. Holt reports 55% of perpetrators are the victims’ sons and Ramsey-Klawsnik finds that sons account for 39% of elder sexual abuse perpetrators.

8. True. Elder sexual abuse victims are unlikely to report abuse.
Only 9% of victims reported abuse in Muran’s study. Not a single victim in Burgess’ study told nursing home administration about the abuse, and only 32% of victims in Ramsey-Klawsnik’s research told anyone about the abuse.

9. True and False. The most common form of elder sexual abuse is vaginal penetration.
The research does not come to a common conclusion. In Teaster’s study, only 5% of victims suffered vaginal penetration, while in other studies, vaginal penetration was the most common form of elder abuse.

10. False. An elder victim is over three times more likely to sustain genital injury from a sexual assault compared to a younger victim.
Averaged from the statistics in the Muran and Ramin studies: Muran indicated 51% had genital injury, compared to 13% in the control group (51/13=3.9) Ramin indicated 43%, compared to 18% in the control group (43/18=2.4) then 3.9+2.4=6.3, then 6.3/2=3.15, rounded down to 3.
Module 3

Handouts

Elder Sexual Abuse
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- Exacerbation of existing illnesses
- Longer recovery times

Emotionally

- Increased chance of sustaining serious injury
- Increased vaginal or anal tearing and bruising that may never fully heal
- Brittle pelvis or hip bones can be broken by friction or weight
- Increased risk of infections
- STDs

Physically

Institutional Sexual Violence
- A more regulated environment—mandatory reporting laws, protective services, Department of Health licensing, ombudsman programs
- Contact with other residents
- Contact with long-term care facility staff

Domestic Sexual Violence
- Limited contact with others
- Family violence

Contact with other residents
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"WHAT DO I HAVE TO LOSE IN ORDER TO FEEL SAFE?"

BARRIERS FACED BY OLDER WOMEN
By Karen Vastine

An interview with an advocate at a Vermont Domestic Violence/Sexual Assault program about how older women have reached out to her and benefited from her program's resources

HTTP://WWW.CCVS.STATE.VT.US/PUB_ED/LOSE.HTML

How have older women contacted you and/or your program?

More often than not, women have contacted our program through a referral. Most often family members have contacted us, but also court staff, the local Area Agency on Aging, and Home Health.

If a family member of a victim or an agency contacts you, what do you do?

First, we will talk to the referring source and assess why the victim is not calling for herself. Then, I only call the victim if the referring source is able to clearly articulate why the victim has a barrier to calling directly.

Then, this practice seems like a departure from your agency's usual policy of allowing the victim to make the first contact.

That is true, but frequently when family members call on behalf of their older relative, they are doing so because the elder is unable to call our program herself. If the older person actually doesn't want to call me, then I won't contact her. I take every measure to make sure that she wants this contact before I call her. After I identify myself to her, I explain that someone had referred her to our program and that I need to make sure that she wishes to talk to me and that it is her choice to talk to me. I also ask if it is safe for her to talk to me. Frequently, because a lot of older women may have difficulty hearing on the phone, I ask if we can meet in person. This option is good because it also helps to ensure that the woman can speak to me confidentially.

What are some of the reasons that an elder may be unable to call your program herself?

The primary reason the women I have served have not directly contacted us is loss of hearing. The elder may not have learned how to use a TTY and so needs support in making phone calls. Also, many nursing home residents do not have access to a private phone, which can make it unsafe for them to call us and disclose personal information within earshot of other residents and staff. Typically, when an elder is referred to our program through a family member, they do not call directly. However, if a woman calls the local Area Agency on Aging helpline, they will have received our phone number and call us directly.
So, what happens when a woman contacts your program? And what are some trends, if any, that you are seeing?

As is true of all victims of crime, it is very unique for each person. A lot of the older women who I have worked with have been victims of sexual assault; many also have called because they are experiencing domestic violence at the hands of their adult children living at home.

A lot of older women I have worked with are not from the traditional domestic violence scenario. There is more sexual violence, more abusive adult kids. Only one woman I have served has experienced domestic violence at the hands of an intimate partner.

In these situations there is more guilt and shame [than with younger women] around getting a Relief from Abuse order (RFA) and calling police to enforce the order. One victim was afraid to call the police because she thought that the police would respond brutally to her son's mental illness. Her son also provided her personal assistance. Some of these women have also been trying to get help for their children/caregivers, with varying responses from the authorities and other agencies.

One woman did get an RFA because she had experienced a great loss: her husband and sister died the same week. And she felt that she could not deal with the abuse and mourn the loss of her family members at the same time.

Would you tell me about the experiences of a couple of women that you have worked with? What challenges have they faced that are the result of their age?

I work with an older woman now who was raped by a stranger. Before she was sexually assaulted, she lived with her family. She was very happy with this arrangement. She was able to get the care that she needed and felt fairly independent.

A stranger broke into her house one night and raped her. She pressed the panic button on her med-alert bracelet and authorities responded immediately. She was unable to see her attacker very well because she has experienced vision loss; however, she thought she had seen him in passing in the town where she lived. In the end, the authorities could not find him, and as a result, she no longer felt comfortable living at home. She moved into a nursing home.

This woman has lost a huge amount as the result of her trauma and victimization. She used to see her family all the time; and now she sees them once every month or two. This was the first time that she experienced an assault, and her life has drastically changed as a result.

How did your first meeting with her go?

The first meeting with her was very awkward. I went to the nursing home to see her. It was difficult to find private space. Women who call our program are usually in a private
space, or we can go to a private space at our program. So, this was a challenge I had not experienced before.

**What types of services do you provide this woman?**

She calls me when she would like to see me and talk. Sometimes I will see her twice a month if she calls me, sometimes less than that. When I visit her, I reassure her and listen to her. She is very lonely; she says that it is helpful when we talk, and I think that she feels emotionally validated. It is interesting that she completely understands that what happened to her was not her fault. I emphasize the strength and courage she showed in her situation. Particularly, I acknowledge her presence of mind to press the med-alert bracelet.

**What do you think made this woman's experience different and more challenging than a younger woman's?**

I think that a real fear for older women is that leaving a painful or scary situation will involve moving to a nursing home. The question that they have to ask themselves is, "How many losses do I have to experience to feel safe?" In this woman's case, she had to lose connection to her family and friends in order to feel that she was not in imminent danger. The cost to her was enormous.

**Is there another woman's experience you can tell me about?**

Another woman I work with lived with her abusive husband for more than twenty years until he passed away. Her son, who has a mental illness, lived with her for quite a while and was assaulting her.

She moved into her own apartment and set her son up with his own housing, too. For a while, this arrangement worked really well and was a great plan. But her son's living arrangement fell through and he came to live with her. Because she had a Section Eight voucher, she was forced to leave because Section Eight rules dictate that she live by herself. She moved on to other places, but was forced to leave those places as well because her son continued to follow her. She is in a homeless shelter right now.

She felt that she could not call the police, because the police in the state where she lived had previously killed a person labeled mentally ill. She was afraid that something like that might happen to her son.

If she could get him housing or bar him from her apartment, she would like to make it work. He is very violent, not just with her.

**What types of services are you providing her?**

Most of what we are providing is hotline support. I connected her with a few different shelters. It has been a lot of hotline advocacy. I have also spoken to APS about her son.
She was considering coming to a support group, but never did. We have talked a lot about RFAs, but that won't work because of her reluctance to call the police. We provide the little things like getting her information and phone numbers, connecting her to resources, helping her make phone calls... A lot of what I am doing is emotional support, which happens on the hotline.

The advocate's experience with elderly survivors can teach us important lessons. She has been able to adapt her advocacy and services to fit what these older women needed. Her program was willing to relax its policy about victims making the first contact, and she has been willing to meet people at nursing homes.

The types of abuse that the advocate has seen are not surprising. Statistically, adult children are the most frequent abusers of elders, followed by other family members and spouses. It is helpful to consider that dynamic when examining how accessible a program or service might be to an elder.

As with all victims, our ability to be with the person, both physically and emotionally, goes a long way to help elderly victims see that domestic and sexual violence programs are there to serve them.
An interview about elder sexual assault with Holly Ramsey-Klawsnik


Holly Ramsey-Klawsnik PhD, of Klawsnik & Klawsnik Associates of Canton, Massachusetts, is a sociologist, social worker, and marriage and family therapist. She has written extensively on elder sexual assault and developed a typology on offenders.

*nexus*: Could you start by describing what constitutes elder sexual abuse?

**Holly Ramsey-Klawsnik**: I define it as situations in which a person over the age of 60 is forced, tricked, coerced, or manipulated into unwanted sexual contact. It also includes sexual contact with elders who are unable to grant informed consent or sexual contact between service providers and their elderly clients.

*nexus*: The issues of mental capacity and consent figure prominently in sexual abuse cases, don't they? Is there agreement as to what type or level of mental capacity is needed for someone to exercise consent to sexual contact?

**HRK**: Determining when someone is able to grant consent to sexual activity is difficult and depends on several factors. The first is the degree of disability. I've had cases in which a wife was comatose and the husband was having sex with her in a hospital bed. Some people want to believe that this is not abuse because she's his wife. But she's clearly not able to grant informed consent and so, in my opinion, that would be abusive. If there's mild dementia, I'd be less likely to consider it abusive as long as there is no force or coercion. In borderline cases, you have to also look at the overall quality of the relationship. If there appears to be a loving and trusting relationship, I certainly wouldn't consider that abusive.

*nexus*: But it's improper for service providers, helpers, and attendants to have sexual contact with clients even if the client is competent and consenting?

**HRK**: Service providers have a responsibility to meet their clients' mental and physical needs and so it is never acceptable for them to use clients to meet their own needs, regardless of whether those needs are social, financial, or sexual. I find that people have an easy time with that as long as the elder didn't want the sexual
Where confusion arises is when the elder didn't refuse or may have initiated the contact. But we need to have these prohibitions because it is so easy for persons in positions of authority to take advantage of elderly clients. Most licensed professionals would lose their licenses for it.

**nexus:** Many older women are unwilling or perhaps unable to tell others that they've been abused. What are the non-verbal indicators to watch for?

**HRK:** Sometimes the signs are very blatant. In a number of cases I've had, the abuse was discovered when a service provider or family member walked into a room and actually witnessed someone sexually assaulting an older person. Others have walked into rooms and seen things that were very suspicious like a caregiver jumping back from the bed and looking upset and worried. Sometimes it is the older person who acts stressed, fearful, or combative when a particular caregiver approaches to bathe or dress them, take them to the bathroom, or care for an injury or wound. That would certainly lead you to suspect that something is wrong and warrants further investigation. It might be sexual abuse, physical abuse, or something else. Other nonverbal indicators include genital irritation, injury, redness, or infection, particularly if it is recurrent and there are no other possible explanations. Sometimes you find evidence of what appears to be physical abuse, like human bite-marks, cigarette burns, or rope burns on wrists and ankles which indicate that the person has been tied up. Thumb or finger imprints on genitals, thighs, buttocks, or breasts could also indicate either physical or sexual abuse.

We've had a number of cases in which a worker has gone into a home and discovered an elderly woman and her middle aged son sharing a double bed. You need to find out if they're sharing the bed because there's no place else to sleep, because of psychological enmeshment, or because there's an incestuous relationship. You have to explore all the possibilities.

I've also had cases that were originally identified as neglect, financial exploitation, or physical abuse but where good investigation yielded proof or disclosure of sexual abuse.

**nexus:** It would seem that seniors in nursing homes would be at extremely high risk. Do we know how the incidence of sexual assault in nursing homes compares with assault in the community?

**HRK:** There's not a lot of research on elder sexual abuse and we still don't know which is more common. What we do know is that we have bona fide, substantiated cases in both settings.

**nexus:** You've served as an expert witness in a number of legal proceedings. Are many cases prosecuted?

**HRK:** Some are, but it's still rather unusual. Often, if the offender is a family member, the victim is unwilling to cooperate in a prosecution so the case needs to be proven through the testimony of third parties and other evidence. I've helped a few district attorneys with cases but I'm more likely to testify in civil cases because most of what I'd have to say would be considered "hearsay" in a criminal case. For
example, if I'd interviewed a victim and he or she had told me that they'd been sexually assaulted, I'm not going to be called as a witness. In a civil case in which an abusive son is the victim's guardian and someone is trying to revoke the guardianship, I might be called as a witness because the testimony I can provide is much more likely to be allowed.

**nexus:** Are the motives or causal factors associated with sexual assault different from those in other types of elder abuse?

**HRK:** Let me address that in relation to the five types of offenders I see with all types of family violence. They are 1) caregivers who are normal and capable of providing good care but who are chronically stressed and lash out through abuse and neglect; 2) people who are well intentioned but who have significant impairments themselves, like physical or mental illness or low IQs, which prevent them from providing adequate care; 3) narcissistic persons with "user mentalities" who get themselves into caregiving arrangements because of what they expect to get out of them; 4) persons with abusive personalities who are unhappy, frustrated, easily angered, and who feel entitled to lash out at others with less power, and 5) sadistic persons who enjoy inflicting harm and terrifying others.

It's unusual to find sexual abuse by persons who fall into the first and second categories. These persons may be neglectful or physically abusive but they don't typically abuse others sexually. Those in the third category, the "users," may use elders for their own sexual gratification although they are more likely to neglect or financially exploit seniors. It is the "fours" and "fives" who are most likely to be sexually abusive. By the way, these offenders are also the most likely to abuse pets, a form of abuse which you discussed in the last issue of **nexus**.

**nexus:** The traumatic effects of sexual abuse must be incredibly intense for elderly victims. Do you find that recovery is more difficult for them than it is for younger survivors?

**HRK:** I've worked with victims of all ages including children who have been sexually abused, young women who have been raped by strangers, and women who have been physically and sexually assaulted by partners. I don't find that age itself makes as much of a difference as victims' pre-assault levels of functioning. People who were functioning well have more resiliency than those who had serious impairments, problems, and limitations. Of course, elderly women are more likely to have these problems; that is what made them vulnerable to sexual assault in the first place.

Other factors that affect recovery are the extent of the abuse, victims' relationships to their abusers, and their support networks. Obviously, the more serious the abuse, the more difficult the recovery. People who are close to their offenders and depend on them will feel more betrayal and have a harder time psychologically. Generally, people with good social support recover quicker. If your victim is 76 years old and has lost her husband and close friends, she is going to have less support than a forty year old woman with a good marriage and close friends.

**nexus:** These cases can be extremely disturbing to service providers, too. What
can you tell them?

**HRK:** Try not to panic. Remember what you already know about investigation, case identification, victim interviewing, and victim protection. You need to respect victims' right to self determination, offer them a continuum of services and interventions, and encourage them to decide for themselves what they want. It's a mistake, especially when the offender is a family member, to assume that a victim will automatically want a restraining order or to have the abuser prosecuted. Other strategies we use with battered women of any age can help elderly women who are being sexually assaulted: empowerment, education, and support in assessing their options. It's also important not to get judgmental and punitive when she doesn't do what we think she should. Sadly, that's a common response.

Service providers also need to know the limits of their knowledge. While much of what we already know about elder abuse is relevant to sex abuse cases, specialized knowledge and interventions are also needed. The problem is that when you need a specialized rape crisis counselor to deal with your 82 year old victim, they're just not there. They don't exist. That's why we need to do some cross training. Let's get the rape crisis center people, the battered women's center people, and the elder abuse people all together. If we give the rape crisis treatment people some training in elder abuse, they'll be there when we need them. And the people who know elder abuse need to be talking to the people who know domestic violence. We need all three pieces. The shared training is so important. It's something that all communities need to do.

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Identified below are common tactics used by abusers. At the hub of the wheel is the intention of all the tactics: to establish power and control. Each spoke of the wheel describes a tactic. The rim of the wheel, which gives it strength and holds it together, is fear and physical abuse, or the threat of it. (Adapted from the Minnesota Coalition for Battered Women by the Vermont Network Against Domestic Violence and Sexual Assault)

**The Power and Control Wheel for Older People**

- **NEGLECT**  
  Withholding food, heat, care. Understanding but failing to follow medical or physical therapy or safety recommendations. Missing medical appointments, not reporting serious symptoms or changes.

- **ISOLATION**  
  Controlling what the person does, whom he or she sees and talks to, where he or she goes, limits time with care resources and friends or family.

- **EMOTIONAL ABUSE**  
  Put-downs, mind games, name calling, ridiculing difficulties, worries and/or fears. Frightening the person by using looks, voice, gestures, moving or hiding a cane, walker, etc.

- **EXPLOITATION**  
  Taking the Social Security check, taking over accounts and bills, spending without permission, drawing up or abusing a Power of Attorney, pressuring for transfer of property.

- **SEXUAL ABUSE**  
  Being rough with intimate body parts, forcing sex against wishes, taking advantage of physical or mental illness to engage in sex.

- **ABUSING DEPENDENCIES**  
  Telling the person how lucky he or she is to have their help; using needs to make this point; creating long waits for food, toileting or other care.

- **THREATS**  
  Making and/or carrying out threats to do things that hurt emotionally or physically. Threats to alienate neighbors, friends, children, to leave, or to institutionalize.

- **USING FAMILY**  
  Magnifying disagreements, past injuries, playing favorites. Misleading members about extent and nature of illness/condition. Excluding or denying access to family members. Using power to ensure secrecy about the abuse; creating alliances against change or support.

Vermont Center for Crime Victim Services Elder Abuse Public Education Campaign, www.ccvs.state.vt.us