SEXUAL VIOLENCE IN LATER LIFE

A TECHNICAL ASSISTANCE GUIDE FOR ADVOCATES

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Sexual violence against people in later life involves a broad range of contact and non-contact sexual offenses perpetrated against people age 60[1] and beyond. The purpose of this guide is to provide information about sexual violence perpetrated against older adults that will increase the effectiveness of advocates' prevention and intervention efforts.

Historically, people in later life have not been considered potential or actual targets of sexual violence. There are many reasons for this, including ageist beliefs that they are not sexual beings and are not sexually desirable. Misconceptions regarding rape, including the myth that sexual assault is a crime of passion rather than a crime of violence, also contribute to people in later life being widely overlooked as victims.

Sexual violence against people in later life is a form of elder abuse. The National Center on Elder Abuse defines elder abuse as the victimization of an older person "by someone who has a special relationship with the elder (a spouse, a sibling, a child, a friend, or a caregiver)" or that occurs "in residential facilities for older persons (e.g., nursing homes, foster homes, group homes, board and care facilities)." Studies show that older people are sexually assaulted in their homes (or domestic settings) as well as in institutional settings such as nursing homes or other care facilities (Burgess, Ramsey-Klawsnik, & Gregorian, 2008; Ramsey-Klawsnik, Teaster, Mendiondo, Marcum, & Abner, 2008).

SEXUAL VIOLENCE AGAINST PEOPLE IN LATER LIFE IS A FORM OF ELDER ABUSE.

Sexual violence perpetrated by those who have special relationships with older adults is often embedded in a pattern of multifaceted elder abuse, especially when the perpetrator has ongoing access to the victim (Ramsey-Klawsnik, 2003). Special relationships often include intimate partners, caregivers, and family members such as adult children. Sexual violence may co-occur with physical or emotional abuse, neglect by a care provider, and financial exploitation. Sexual assault advocates can be instrumental in bridging gaps in intervention and prevention regarding elder sexual violence and in ensuring that such efforts are tailored to the specific needs of people in later life. (For definitions of terms used throughout this guide, please see the Glossary at the end.)

PREVALENCE OF SEXUAL VIOLENCE IN LATER LIFE

The true prevalence of sexual violence against people in later life is unknown for a number of reasons, including the fact that research about this problem is in its infancy (Burgess, Hanrahan, & Baker, 2005; Poulos & Sheridan, 2008). A small minority of victims seen at hospital emergency departments and sexual assault crisis centers are over the age of 60 (Burgess et al., 2008). However, there is reason to believe that the underreporting of sexual violence against older adults is much higher than for those of other age groups (Burgess & Clements, 2006).

Myths and ageist beliefs cause people in later life to be overlooked as potential and actual sexual assault victims. Generally, people do not believe that people in later life are targets of sexual assault. Due to generational issues and these myths, shame and barriers surrounding the discussion of sex and sexual violence openly, may be worse for older victims, thereby reducing help seeking and reporting.

Many older victims have conditions such as dementia and stroke-induced aphasia that prohibit them from reporting (Ramsey-Klawsnik, 2009). Some older victims who have reported sexual assault have not been believed but have instead been presumed to be psychotic or demented (Ramsey-Klawsnik, 2009). Abusive relatives and care providers often deny older victims an opportunity to report through tactics such as blocking access to telephones and visitors. Additionally, perpetrators of sexual violence against people in later life may use conditions such as dementia, aphasia, or others to discredit and isolate older victims.

Physical indicators of sexual assault are often missed by health professionals and care providers on an older body due to lack of awareness of the potential for sexual violence in later life (Burgess & Clements, 2006). Training for Sexual Assault Nurse Examiners and other medical providers typically does not include information on how to evaluate older victims for sexual assault (Burgess & Clements, 2006).

AGE, GENDER, AND OTHER DEMOGRAPHIC ISSUES

Sexual violence victims of all ages have been identified including people up to age 100 (Burgess et al., 2008). Like younger victims, the majority of reported older victims are female (Burgess et al., 2008; Ramsey-Klawsnik et al., 2008). Identified perpetrators have ranged from juveniles to elders (Burgess et al., 2008). Most reported perpetrators of elder sexual violence are male. Because research is in its infancy, information about the demographic and cultural variables at play in sexual violence against people in later life has not yet been identified. However, it has been determined that a majority of victims experience cognitive, functional, and physical limitations (Eckert & Sugar, 2008; Ramsey-Klawsnik et al., 2008; Teaster & Roberto, 2004).

SIGNS AND SYMPTOMS

Indicators of sexual violence against people in later life include physical signs such as genital, anal, throat, and oral injuries; bruising on breasts, buttocks, thighs, neck, and other body areas; imprint injuries; human bite marks; and sexually transmitted disease diagnosis (Burgess et al., 2008, Eckert & Sugar, 2008, Ramsey-Klawsnik, 2003).

Some victims display psychosocial trauma symptoms including sleep disturbances, incontinence, increased anxiety, crying spells, withdrawal, depressive symptoms, agitation, restlessness, decreased enjoyment in activities, intrusive memories, and attempts to leave care facilities in which they were previously willing to remain (Burgess et al., 2008).

Disclosures by victims as well as eyewitness reports of sexual assaults can result in the identification of cases (Ramsey-Klawsnik et al., 2008). Intimate partners may admit sexual assault and justify their behavior by expressing views of their wives as "sexual property" (Ramsey-Klawsnik, 2003). In other cases, suspicious behavior by alleged perpetrators is witnessed. For example, in some incest cases, adult sons have been observed sharing the beds of their older mothers suffering from dementia (Ramsey-Klawsnik, 2003). Unfortunately, indicators of possible sexual violence against people in later life have often been missed, misinterpreted, or disbelieved by care providers (Burgess & Clements, 2006; Ramsey-Klawsnik, 2004; Ramsey-Klawsnik et al., 2007).

TYPES OF SEXUAL OFFENSES

Like younger people, older victims have been exposed to a broad range of sexual abuses. Contact offenses experienced include oral, anal, and vaginal rape, molestation, and sexualized kissing. Non-contact offenses include sexual harassment and threats, forced pornography viewing, using older adults to produce pornography, exhibitionism, and exposing the victim's breasts or buttocks as a form of humiliation.

SEXUAL VIOLENCE AGAINST PEOPLE IN LATER LIFE OCCURS IN DOMESTIC SETTINGS IN THE FORM OF INTIMATE PARTNER VIOLENCE AND INCEST.

An additional form of sexual violence against people in later life involves unnecessary, obsessive or painful touching of the genital area that is not part of a prescribed nursing care plan. Examples include inserting spoons or fingers into an older adult's rectum and cleansing inner and outer vaginal areas with alcohol wipes. Typically, perpetrators claim that these behaviors are necessary for the health or hygiene of the involved victim, despite medical warnings that these behaviors are potentially harmful as well as painful (Chihowski & Hughes, 2008; Ramsey-Klawsnik, 1996). Sexual homicides of older people also occur (Jeary, 2005; Safarik, Jarvis, & Nussbaum, 2002).

PERPETRATORS

Sexual violence against people in later life occurs in domestic settings in the form of intimate partner violence and incest (Burgess et al., 2008; Ramsey-Klawsnik, 2003). It also occurs as a form of abuse of power in institutional settings. Care providers in both community and institutional settings have sexually assaulted older adults who depended upon them for assistance (Burgess et al., 2008). Resident-to-resident sexual assault also occurs in care facilities (Ramsey-Klawsnik, 2004; Ramsey-Klawsnik et al., 2008). Like people of all ages, older adults are also vulnerable to stranger and acquaintance assault (Burgess et al., 2008).

ILLUSTRATIVE CASES OF SEXUAL VIOLENCE AGAINST PEOPLE IN LATER LIFE

The documented cases below illustrate the dynamics of sexual violence against people in later life, offender behaviors, and problems commonly experienced by victims. The following cases (in which all identifying information is concealed) provide the real-life context in which sexual violence against people in later life takes place.

Intimate Partner Sexual Violence

> *Sixty-year-old Mrs. V. has been married for forty-one years, and is the mother of six adult children. She is diagnosed with clinical depression, onset during menopause. Her son sought assistance for her due to marital rape. During an Adult Protective Services (APS) investigation, Mrs. V. acknowledged that throughout her marriage she had been hit and sexually assaulted by her husband. There was also an extensive history of Mr. V. physically abusing the children when they were young. Mrs. V. has not been hit in many years but her husband continues to dominate and rape her. He also prohibits her from driving, working outside of the home, or managing money, rendering her extremely dependent upon him. Although Mrs. V. has received psychiatric treatment for 12 years, the ongoing intimate partner violence was unknown to the mental health professionals providing her treatment (excerpted from Ramsey-Klawsnik, 2003).*

This case illustrates long-term, multi-faceted intimate partner violence in which the victim was silent about her assaults until a caring person sought assistance for her. Despite Mrs. V.'s long involvement with the mental health system, her victimization had remained undetected for years. Mr. V. admitted to APS staff that he forced his wife sexually and expressed that this was his right. This shows the ways that belief systems at a particular point in time or set within a specific culture can influence how perpetrators view and justify their own actions. Mr. and Mrs. V. were born and raised outside of the U.S. and both seemed unaware of legal protections and services for domestic violence and sexual assault victims. Like many older intimate partner victims, Mrs. V. did not want to end her marriage but did want intervention to live free of sexual assault.

Incest

Adult child offenders

> *Eighty-three year old Mrs. M. resided on a dementia unit of a nursing home. Mrs. M. asked nursing home staff when her son would visit, saying that she has sex with him. This statement was considered the result of cognitive confusion, until a Nurse Aide witnessed the son fondling his mother's genitals during a visit (Ramsey-Klawsnik, 2003, p. 50).*

People in later life who have serious cognitive disabilities are at high risk of victimization and of being disbelieved if they disclose sexual assault. The aide who witnessed the molestation stated that she could not believe that a son would touch his mother in this way. Despite her report of this observation to the facility management and Mrs. M.'s abuse disclosures to other staff, the situation

was not reported to state authorities. As a result, Mrs. M. remained unprotected from continued sexual assault during the frequent visits from her son. Eventually, the case came to the attention of Adult Protective Services and intervention stopped the assaults. Mrs. M.'s behavior revealed ambivalent feelings regarding her son. The aide had witnessed

THESE CASES ILLUSTRATE THE RANGE OF ABUSES TO WHICH PEOPLE IN LATER LIFE MAY BE SUBJECTED.

Mrs. M. push her son's hand away and repeatedly state, "No" during the molestation. However, Mrs. M. continued to ask to see her son who was her next-of-kin and only visiting relative. This shows the complexities surrounding sexual violence committed by loved ones. Reporting a family member may undermine family relationships that may in part be rewarding, loving, and helpful despite the abuse.

Other relative offenders

> *Mrs. J. is eighty-six years old. She moved into the home of her daughter and son-in-law to recover from a broken hip. Several months later, her daughter died and her son-in-law, Charlie, became her caregiver. Mrs. J. disclosed to her visiting nurse that Charlie took nude photos of her. He instructed Mrs. J. to open her legs and smile for the camera. He told her that he needed the photos to have evidence that he had not abused her and that her daughter would want her to cooperate. Charlie also told Mrs. J. that as a care provider he needed to "check" her genitals, which involved him pushing something large in and out of her vagina. The nurse filed an elder abuse report triggering criminal and Adult Protective Services investigations, as well as an arrest of Charlie and intervention services for Mrs. J. It was learned that Charlie earned his living as a home health aide (excerpted from Ramsey-Klawsnik, 2003).*

These cases illustrate the range of abuses to which people in later life may be subjected as well as the manipulative nature of many perpetrators. They may seek out employment and other opportunities to exert coercive control over dependent individuals. It is critical that health care and aging services personnel receive training in recognizing and responding to sexual violence against people in later life. The excellent response of the visiting nurse led to the protection of Mrs. J. from further assaults and the provision of sexual assault services that were tailored to her special needs. The prompt report to law enforcement resulted in the confiscation of the photos and conviction of the son-in-law.

Institutional Sexual Violence

Care facility staff offenders

> *A male direct care attendant in a community mental health and mental retardation facility was identified as an alleged sexual perpetrator in a report to Adult Protective Services. He was accused of committing emotional and sexual abuse against a 65-year-old male resident.*

Suspicion was raised by observed anxiety in the victim and by burns on his arm and tearing of his rectum. The worker was accused of engaging in harmful genital practices and anally raping the older man with an object. The perpetrator admitted only physical abuse and bruising the victim's genitals (excerpted from Ramsey-Klawsnik et al., 2008).

It is important to remember that older males are also at risk of sexual assault, particularly when they have disabilities. Despite the presence of compelling medical evidence, this perpetrator was criminally charged only with physical assault. Additionally, male victims may experience compounded barriers to reporting sexual violence and to being believed due to general thinking that sexual violence is a "woman's issue." Social stigma attached to sexual victimization among males may be higher than for females, especially in certain cultural groups with more traditional definitions of masculinity. All of these factors can contribute to underreporting of sexual violence among males.

Resident offenders

"Sixty-seven-year-old Mr. N. suffered from chronic mental illness, long-term alcoholism, and a host of physical problems. He required constant supervision and medical management and was placed in a nursing home. Facility staff soon realized that Mr. N. presented a severe supervision challenge in that he was repeatedly found sexually molesting women who resided in the facility. All of

his victims were more physically and cognitively impaired than he. Some suffered from advanced dementia, some were aphasic or paralyzed. Many were assaulted in their beds or wheelchairs" (Ramsey-Klawsnik et al., 2007).

The vulnerability of older adults living in care facilities to sexual assault by other residents is illustrated by this case. Many who have been sexually assaulted in facilities (by either staff or other residents) have found themselves completely unable to escape ongoing assaults due to their health limitations and placement status. Facility staff and administration face complex challenges in managing sexually aggressive residents and protecting those under their care. This underscores the importance of prevention efforts and early intervention when sexual violence is first disclosed by victims or identified by care providers. These challenges are discussed in Ramsey-Klawsnik et al. (2007).

Acquaintance Sexual Violence

Ms. P., a sixty-four–year-old woman with long-term schizophrenia, was admitted to a state mental hospital due to active psychosis. She disclosed to a nurse that just before her admission that a neighbor sexually assaulted her. The nurse was tempted to attribute Ms. P.'s statements to her psychiatric condition, but charted them, notified the treating physician, and reported to law enforcement. The registered nurse (R.N.) requested that the physician order an exam by a Sexual Assault Nurse Examiner (SANE). The police initially believed the report to be without merit, however, DNA evidence was found during the exam. A criminal records check revealed that the neighbor had a history of conviction for sexual assault. While initially it appeared that the disclosure was merely a result of a psychotic episode, evidence suggested that in fact the sexual assault had triggered Ms. P.'s decomposition (excerpted from Ramsey-Klawsnik et al., 2007).

There can be a temptation to discount sexual assault disclosures made by older adults with mental health conditions as illustrated above. It is critical that professionals serving people in later life take all sexual assault indicators seriously and offer forensic examinations and supportive services and advocacy to those who may have been assaulted and receive appropriate training that enables them to do so.

SPECIAL ISSUES FACING OLDER VICTIMS OF SEXUAL VIOLENCE

Older people who have been sexually assaulted face many of the same problems as younger victims. Special issues confront people in later life, however, and advocates who are informed about these issues will be better prepared to effectively assist older victims and to educate others.

Aging Issues

Normal physiological changes occur as people age. These include changes in memory and sensory abilities such as sight and hearing. Advanced age brings declines in dexterity and mobility, lowered immune functioning, and changes in the functioning of virtually every body organ. Bones become more brittle, skin more fragile, and tissue more easily damaged. Older people are more easily injured and heal much more slowly than younger adults. They typically process information more slowly than younger people because of age-related changes in brain functioning. Normal physiological changes put people in later life at elevated risk of many chronic conditions including arthritis, hypertension, heart disease, and diabetes. Additionally, the likelihood of becoming disabled escalates. These factors can reduce self-care abilities, increase dependence upon others and vulnerability to interpersonal violence, and increase the severity and consequences of injuries sustained.

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Generational Thinking

"Today's elder victims grew up in a world of sexism, where even the rape crisis movement discriminated on the basis of age, race, and gender. This affects how elders experience and view sexual victimization" (Vierthaler, 2008, p. 309).

Older adults were raised in a society very different from that of today. While rape is still not openly discussed and victims are often blamed for causing their own assaults even in today's society, stigma and victim-blaming were even more pronounced during the formative years of older generations. Having heard these messages for most of their lives, older victims may feel intense shame and embarrassment, suffer in silence, and be reluctant to seek sexual assault services and justice under the law.

Issues surrounding intimate partner violence are especially complex. When today's older adults were young, resources such as restraining orders, shelters, and sexual assault services were unavailable because they were never thought necessary. Until the 1970's, there was little social support for women's rights to protection from domestic violence and there were no legal protections from marital rape. Individuals who have experienced decades of domestic violence often suffer extensive deterioration of self-esteem and sense of empowerment. Older abusers, on the other hand, may feel justified in sexually assaulting wives whom they consider to be their property. Brandl (2000) discusses

intervention strategies and approaches for these complex cases. She stresses that the primary focus of the work must be victim safety. Key goals include breaking the victim's isolation (and hence dependence upon and vulnerability to the perpetrator) and holding the perpetrator accountable through collaboration with the criminal justice system.

Older victims who have been sexually assaulted by their children or grandchildren also face special challenges. Many experience powerful and often conflicting feelings towards their abusers including love, fear, and disgust. These feelings complicate the trauma response and make it difficult to accept intervention. Fear that kin will be prosecuted, shame over the nature of the crime, sense of responsibility for the wrongdoing of offspring, and familial bonds of attachment can cause victims to suffer in silence. These are serious generational issues that must be planned for and considered in service delivery. Additional psychosocial issues facing older incest victims are further discussed in Ramsey-Klawsnik (2003, 2006).

Mandated Reporting Requirements

Throughout the nation, legislation requires certain individuals to report alleged elder abuse, including sexual assault, to state authorities. The purpose of reporting laws is to protect victimized elders who are unable to independently seek assistance. Legal requirements mandate that professionals report any form of suspected elder abuse, including sexual assault, to Adult Protective Services (APS) and in some cases, also report to other state authorities such as Departments of Public Health. Typically health care, criminal justice, social work, aging services, and other professionals are mandated to report suspected cases to APS. In institutional cases, reports to state Departments of Public Health and licensing authorities are usually required. Reports to long-term care Ombudsman offices may also be required and/or helpful. Laws vary somewhat from state-to-state. It is critical that advocates know and follow applicable reporting laws. Information about reporting laws can be obtained from APS programs, Departments of Public Health, or legal consultation.

PRIMARY PREVENTION OF SEXUAL VIOLENCE AGAINST PEOPLE IN LATER LIFE

A goal of primary prevention is to create environments in which people are safe in their relationships, homes, and other locations (Davis et al, 2006). Said another way, primary prevention means preventing sexual abuse before it occurs. This work requires a range of efforts at all levels of society: individual, relationship, community, and societal. Advocates play a critical role in these efforts. For more information about primary prevention, please see Centers for Disease Control and Prevention (2004) and Davis, Parks, and Cohen (2006).

Strategies to prevent sexual violence against people in later life need to be developed and implemented. The first step in prevention is the recognition of "the extreme vulnerability of elders to sexual assault," (Burgess et al., 2008, p. 348). Additionally, research is needed regarding prevalence rates, forensic markers, best practices for preventing assault in later life and early case identification, victim impact, effective treatment methods, and methods for managing perpetrators.

Prevention at Individual and Relationship Levels

Providing outreach to people in later life and increasing their awareness about sexual violence is an important step towards prevention. Creating and disseminating sexual assault awareness materials geared towards older adults, including public service announcement, are ways of increasing awareness. Presentations at senior centers and other places where people in later life gather can be important means of making contact. Gaining an understanding of where people in later life gather and find support in your community and developing collaborative partnerships and educational opportunities with those groups can be an important prevention strategy. This may include senior centers, clubs, and faith-based organizations.

PRIMARY PREVENTION MEANS PREVENTING SEXUAL ABUSE BEFORE IT OCCURS

Discussions that address the myths and realities of sexual violence, healthy alternatives to violence and abuse, protective measures, and accessing sexual assault services can invite dialogue and begin to break down barriers. Bystander intervention may also assist in preventing sexual violence against people in later life by equipping peers, caregivers, family members, and other community members with tools to intervene effectively.

In thinking about the primary prevention of perpetration, it is critical that building skills and awareness around healthy norms and relationships start early and continue over the course of the lifespan. Exhibiting healthy relationships that are based on mutual respect, trust, and equality are paramount. Once a perpetrator has reached later life, it is critical that individual interventions occur to help prevent recidivism, connecting individuals to appropriate treatment and supportive services and holding them accountable for their actions.

Prevention at Community Levels

Collaboration with organizations and providers who routinely provide services to people in later life is a critical component in sexual violence prevention. Targeted settings could include community senior centers, housing for elders, nursing homes, hospitals, aging services such as home-delivered meal programs, visiting nurse associations, and faith communities.

STAFF RECRUITMENT AND TRAININGS SHOULD CONVEY A STRONG EMPHASIS ON ZERO TOLERANCE OF ABUSE OF OLDER ADULTS

Employees of Councils on Aging, Adult Protective Services, visiting nurses, home care services, senior centers, adult day health programs, nursing homes, and other aging services who routinely interact with older adults are likely to encounter victims. They need to become informed allies in this effort, trained to recognize indicators, and prepared to respond effectively to sexual assault evidence. Ramsey-Klawsnik et al. (2007) discuss the role of nurses in preventing sexual assault of residents in care facilities.

Employees and volunteers should be part of an education and awareness campaign on sexual violence against people in later life as well as bystander intervention so if they observe or witness abuse, they can effectively intervene. All facility staff must be trained in residents' rights, all forms of abuse against people in later life, signs and symptoms of sexual assault, measures to protect actual and potential victims, the duty to report alleged assault, preserving assault evidence, and accessing sexual assault exams and other services for alleged victims.

Organizational policies should be in place to effectively prevent and respond to sexual abuse of people in later life. Staff recruitment and trainings should convey a strong emphasis on zero tolerance of abuse toward older adults and a clear articulation of organizational response. Responsibilities include practicing due diligence in recruiting, screening, employing, training, and supervising personnel so that potential and actual sexual perpetrators are prevented from gaining positions of authority over vulnerable adults. Planning and delivering safe care to older adults, along with other recommendations for social work and related professionals, is discussed in Ramsey-Klawsnik (2009).

Prevention with Larger Society

"Law enforcement officers, nurses, and physicians (among others) need a heightened awareness toward cases of elder sexual assault," (Poulos & Sheridan, 2008, p. 333).

Often, the pathway to help has been blocked for older adults who have been sexually assaulted. Barriers include the fear and shame of victims, lack of awareness and training among professionals,

and perpetrators and others motivated by self-interest to hide assaults. When ageist beliefs and misconceptions are removed, pathways to help for older sexual violence victims can be more easily traveled. Advocates can assist victims by raising awareness that older adults are vulnerable to sexual assault and by working with allied professionals in identifying signs, symptoms, and risk factors for sexual violence.

Preventing perpetration in later life poses a challenge. Research and prevention strategies are still in infancy with regards to the primary prevention of sexual perpetration among older offenders. It is critical that early intervention occur with perpetrators, at the beginning of the life span as way to prevent ongoing sexual offenses against multiple victims over many years. Challenging the myths that surround sexual violence as a crime of passion rather than a crime of violence is critical in raising awareness about sexual violence against people in later life. Social norms that promote healthy and respectful relationships and communications across the lifespan are also key components of the prevention of sexual violence in later life.

Measures that can increase awareness regarding sexual violence in later life include expanded research on the prevalence, victim impact, perpetrator behaviors and their methods of obtaining access to victims. To date, limited research has occurred and little funding has been made available for this inquiry. The elucidation of the extent of the problem and the degree to which people in later life are physically and psychosocially harmed by sexual assault will help to make sexual violence in later life better recognized and better understood. Perpetrator data will inform the development of prevention strategies. Sexual assault centers can contribute to research by collaborating on studies and contributing data. Demographics are changing dramatically in the United States; people age 65 and older are expected to represent 20% of the population by 2030 (U.S. Administration on Aging, 2009). It is imperative that as the anticipated number of older sexual assault victims rises, our knowledge base and ability to both prevent and respond to this problem also increases.

ROLE OF ADVOCATES IN PRIMARY PREVENTION OF ELDER SEXUAL ABUSE

Advocates can serve as consultants to such providers in developing trainings, policies, and protocols to prevent sexual violence in their organizations and facilities. Training and networking with individuals employed in long-term care, assisted living facilities, and senior housing can help to make living environments safer for elders. For more information, see Vierthaler (2004).

How Advocates Can Help

"Despite the widespread availability of rape crisis services, elders generally are not seeking or being linked to these services when they are sexually assaulted," (Vierthaler, 2008, p. 315).

Individuals involved in identifying and responding to sexual violence against people in later life can be more effective when they have an understanding of aging and generational issues as well as the special needs of older victims. There are a number of steps that sexual assault advocates can take to insure that older victims of sexual assault are recognized, protected, and served.

Sexual assault centers can be more user-friendly for people in later life when such centers are accessible both structurally and attitudinally to older adults. People in later life may be uncomfortable discussing highly private matters with very young advocates. When staff and volunteers represent a variety of ages, older victims may feel more at ease. Understanding this, advocates can prepare to help older victims move past paralyzing feelings of self-blame and shame though counseling, support groups, and psycho-education. Further discussion of this topic is provided in Vierthaler (2008). See California District Attorneys Association (CDAA, 2003) training video for suggestions on interviewing and working with elder victims.

Physical accessibility issues facing older victims may include those contained in the Americans with Disabilities Act such as providing accommodations for mobility and sensory impairments. Accommodations may also include offering an older victim with hearing loss the use of a personal listening device to augment sound during counseling sessions. Advocates may need to slow the rate at which they provide information and allow older victims time to formulate their thoughts and put those thoughts into words. Due to normal memory changes, people in later life may need to have information repeated or written down. Allow extra time, if needed, when working with older persons who have special needs. Additional accommodations that may be required by elders are discussed in CDAA (2003) and Wisconsin Coalition Against Sexual Assault (1998).

Providing bus tokens, taxi fares, and reimbursement for travel may help some older victims to more easily access services. Victims with extensive mobility limitations are often unable to travel to a sexual assault center. Centers may need to provide telephone counseling or meet with a victim at a safe but easily accessible location, such as a facility providing elder care.

Some older victims do experience significant disabilities, including cognitive loss, dementia, and in some cases, inability to make informed decisions. Although long-term counseling would not be effective, it is still important that the advocate provide clear information, in a calm and reassuring manner. While they may not remember the details, the victim may remember that a kind person tried to help them and treated them respectfully.

Many victims who experience sexual violence in later life have endured multiple victimizations over the course of their lifespan. They may have experienced child sexual abuse, intimate partner violence, sexual violence in adulthood, and other types of violence. Advocates can be instrumental in addressing the immediate needs of older victims and connecting them with helpful support services that address the scope and magnitude of their experiences.

Advocates may also help elder victims with severe limitations in self-care ability by consulting with their guardians or loved ones regarding the psychosocial impact of sexual assault and ways to facilitate healing. For example, Burgess et al. (2008) and Ramsey-Klawsnik et al. (2008) found that older victims who had been victimized in their care facilities experienced pervasive feelings of being unsafe there and urgent desires to leave those facilities. Information sharing may help guardians and loved ones to understand that removing victims from the locations of assault can lessen feelings of terror.

Additional suggestions for improving services to people in later life (adapted from the National Clearinghouse on Abuse in Later Life):

- Talk to older people in your community - they are the experts on how to enhance services to meet the needs of those in later life.
- Put older people in positions of power in your organization - get and keep several older board members and staff who can look at policy and practice and identify ways to better assist older victims.
- Assess your facility - is it user-friendly for older victims and people with disabilities?
- Be prepared for older victims to contact your center. Is staff willing to meet them in a safe place to talk if they can't get transportation to your center?
- Work collaboratively with aging units and adult protective services/elder abuse agencies with expertise in working with older victims.
- Be creative and flexible. As with all victims, the key to being successful with older people is listening carefully and giving them time to make decisions. See the National Clearinghouse on Abuse in Later Life (http://www.ncall.us) for further suggestions on meeting the needs of people in later life who have been victimized.

CONCLUDING THOUGHTS

Advocates and allied organizations can work together to prevent sexual violence against people in later life and to ensure that older adults are no longer forgotten victims of sexual assault, are not left unprotected from continuing assaults, and are not deprived of sexual assault services. The physical and psychosocial impact of sexual assault on older adults is often missed, minimized or ignored. Many people in later life have not been protected from ongoing assaults even after victimization has been recognized. Older victims are infrequently offered forensic exams or sexual assault counseling. Education and advocacy can help to ensure that hospital personnel, investigating police officers, and prosecuting attorneys are better equipped to identify and prevent sexual violence and to accommodate the special needs of older victims. Partnering with services that assist victims in later life can bring the expertise of sexual assault advocates to victims. For example, many communities have multi-disciplinary elder abuse teams (discussed in Brandl et al., 2007) consisting of representatives from APS, health care, law enforcement, and other services. The purpose of the teams is to bring together needed expertise and provide a coordinated and effective response to older victims of sexual and other forms of violence. A sexual assault advocate is an invaluable member of such a team.

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GLOSSARY

Adult Protective Services (APS) – statewide service organizations that are legally charged with the responsibility to receive reports of alleged abuse, neglect, exploitation or self-neglect of adults who are elderly or have disabilities. APS also is responsible for investigating these reports and providing services to protect victims

Ageist – discriminatory remarks, beliefs or behavior against a person based upon that individual's advanced age

Aphasia – the partial or total inability to produce and understand speech as a result of brain damage (common following a stroke; but can be temporary)

Decompensation – the deterioration of existing psychological defenses in an individual

Dementia – the usually progressive deterioration of intellectual functions including memory due to a disease process

Domestic abuse - forms of maltreatment of an older person by someone who has a special relationship with the elder (a spouse, a sibling, a child, a friend, or a caregiver), that occur in the elder's home, or in the home of a caregiver (NCEA, 2007)

Elder – a person of age 60 years and beyond

Imprint injuries – injuries resulting from an object being used to inflict physical harm such as a belt or fingers, the resulting injuries will be in the shape of the object used to harm

Institutional abuse - forms of abuse that occur in residential facilities for older persons (e.g., nursing homes, foster homes, group homes, board and care facilities) (NCEA, 2007)

Harmful genital practices - unnecessary, obsessive or painful touching of the genital area that is not part of a prescribed nursing care plan

NATIONAL SEXUAL VIOLENCE RESOURCE CENTER

The National Sexual Violence Resource Center (NSVRC), founded by the Pennsylvania Coalition Against Rape, opened in July 2000 as the nation's principle information and resource center regarding all aspects of sexual violence. The NSVRC provides national leadership in the anti-sexual violence movement by generating and facilitating the development and flow of information on sexual violence intervention and prevention strategies.

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