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Elder Sexual Abuse

By Holly Ramsey-Klawnsnik, PhD

Learning Objectives

- 1) Learners will describe five types of elder sexual abuse cases identified in clinical practice.
- 2) Learners will list five research findings regarding sexual violence perpetrated against older adults.
- 3) Learners will provide three responsibilities of social work and related professionals in regard to situations of elder sexual abuse encountered in practice.

Introduction

Need for Professional Education & Information

During the past quarter century, society has made considerable strides in recognizing the problem of sexual violence, responding to victims, and attempting to hold perpetrators accountable. Recognition of older adults as potential and actual victims, however, has lagged considerably behind the realization that other age groups are vulnerable to sexual assault. Ignorance and myths have contributed to the hidden nature of sexual violence against older adults, primarily notions that elders are not sexually attractive or active and that sexual violence is a crime of passion. "This age group is viewed as asexual and ignored as possible victims of sexual assault" (Poulos and Sheridan, 2008, p. 333). Other experts agree, "Until recently, it has historically and widely been beyond comprehension and belief that elders are victims of sexual assault" (Burgess and

Clements, 2006, p. 119). Vierthaler (2008) discusses rape myths and the history of the rape crisis movement and states that elders have been "both overlooked as potential targets and underserved as victims" (p. 306). Furthermore, "elder sexual abuse is a complicated issue — one that is rarely recognized, acknowledged, researched, or treated" (Vierthaler, 2004, p. 2).

In recent years, the federal government has recognized the need for increased research into this problem. This is evidenced by major research grants awarded by the Department of Justice (described in Schofield, 2006) and the National Institute on Aging (described in Ramsey-Klawnsnik, Teaster, and Mendiondo, 2007 and Ramsey-Klawnsnik et al, 2007). Clinicians and researchers have identified the need for dissemination of available information and continued research (Burgess and Clements, 2006; Burgess, Ramsey-Klawnsnik and Gregorian, 2008; Chihowski and Hughes, 2008; Poulos and Sheridan, 2008; Ramsey-Klawnsnik, 2008; Ramsey-Klawnsnik et al, 2007; Teaster and Roberto, 2004; and Vierthaler, 2008).

Social workers play a key role in planning, managing, supervising, and delivering services to older adults across many community and institutional settings. It is essential, therefore, that they are knowledgeable about this form of sexual and elder abuse and prepared to respond ethically, compassionately, and effectively.

Goal and Focus of the Article

The goal of this article is to provide information about elder sexual abuse (ESA) and to equip social workers and related professionals to: (1) recognize

the vulnerability of older adults to sexual assault, (2) help prevent this form of victimization, (3) recognize forensic markers, and (4) respond appropriately to alleged and confirmed cases.

The National Center on Elder Abuse (2007), which is funded and directed by the U.S. Administration on Aging, distinguishes abuse perpetrated against elders into domestic and institutional categories:

Domestic abuse involves "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."

Institutional abuse refers to "forms of abuse that occur in residential facilities for older persons (e.g., nursing homes, foster homes, group homes, board and care facilities). Perpetrators of institutional abuse usually are persons who have a legal or contractual obligation to provide elder victims with care and protection (e.g., paid caregivers, staff, professionals)."

ESA is often embedded in a pattern of multifaceted elder abuse, whether it occurs in domestic or institutional settings. This is particularly likely when the perpetrator has ongoing access to the victim. Co-existing abuse may include physical or emotional abuse, neglect by a care provider, and financial exploitation. Information about specific forms of elder abuse other than sexual is beyond the scope of this article. Social work professionals also require education about other types of elder abuse, particularly if they routinely provide services to older adults. It is important to note, however, that practitioners engaged in all clinical settings encounter elder abuse

even if they do not specialize in gerontology. Information about all forms of elder abuse is available from the National Center on Elder Abuse (www.ncea.aoa.gov), the National Committee for the Prevention of Elder Abuse (www.preventelderabuse.org), Bonnie and Wallace (2003), and Brandl et al (2007), among other sources.

Topics To Be Covered

This article provides information regarding elder sexual abuse that occurs in both domestic and institutional settings. A compilation of the currently available clinical and research findings regarding ESA is provided. Professional roles and responsibilities in regard to this form of interpersonal violence are delineated.

Specific topics covered include definitions and dynamics of elder sexual abuse. Types of cases confronted in clinical practice are discussed, including intimate partner violence, incest, other community cases, and institutional assault perpetrated by staff and residents. Documented cases in which identifying information has been concealed illustrate frequently observed clinical dynamics, including problems confronting victims. Incidence and prevalence of the problem is addressed. Research findings are presented regarding identified victims and perpetrators, forensic markers, abuse acts, and harm incurred by victims. Professional responsibilities are delineated. These include helping to prevent elder sexual abuse, responding appropriately to indicators of ESA, reporting alleged cases, and complying with other legal and ethical requirements. The social worker's role in intervention and treatment is also addressed with tips for providing effective and compassionate response.

Defining Elder Sexual Abuse (ESA)

The World Health Organization (WHO) defines sexual violence as,

“Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work” (Jewkes, Sen, and Garcia-Moreno, 2002, p. 149).

WHO further states that coercion can include, “Physical force... psychological intimidation, blackmail or other threats –for instance, the threat of physical harm...It may also occur when the person aggressed is unable to give consent – for instance, while...mentally incapable of understanding the situation” (Jewkes, Sen, and Garcia-Moreno, 2002, p. 149).

The NCEA (1995) defines sexual abuse as “non-consenting sexual contact of any kind” (p.1). This includes unwanted touching; sexual assault or battery, such as rape, sodomy, and coerced nudity; sexually explicit photographing; and sexual contact with any person incapable of giving consent.

Legal definitions vary somewhat from state to state. In Massachusetts, regulations define elder sexual abuse in the following manner,

“Sexual abuse includes unwanted sexual acts, sexual misuse or exploitation and threats of sexual abuse... There are a variety of offenses that meet the standard of sexual abuse. These include, but are not limited to, rape, attempted rape and sexual assault (the unwanted touching of an elder on the sexual parts of his/her body or in a sexually provocative manner). Sexual abuse also includes threats of sexual abuse, as well as objectionable conduct such as exposing one's self, taking sexually oriented photographs of an elder, or performing sexual acts in front of an elder without his/her consent. An unwanted sexual advance toward an elder with the capacity to consent, such as an unwelcome kiss or making sexually suggestive comments directed at an elder, is sexual abuse if the person's behavior continues after he/she is told to stop. However, if an elder does not have the mental or physical capacity to refuse the overture, any sexual advance is sexual abuse” (MA General Laws, 2004, 651 C.M.R. 5.00).

Various jurisdictions and agencies define the “elder” portion of life differently but typically as commencing at either 60 or 65. In contrast, the National Clearinghouse on Abuse in Later Life (NCALL), funded by the US Department of Justice (Brandl et al, 2007), considers victims over the age of 50 to be “older.” In Massachusetts, an elder is defined as, “an individual who is 60 years of age or over” (MA General Laws, 2004, 651 C.M.R. 5.00).

A variety of types of ESA cases present in clinical practice. Dynamics, including impact on victims and problems confronting them, differ somewhat among the various types. In this section, documented cases will be presented to illustrate the vulnerability of older adults to sexual violence, patterns of victimization, and behaviors displayed by offenders. A discussion follows of the problems commonly experienced by victims in the aftermath of sexual assault.

Intimate Partner Violence (IPV)

Many cases of ESA coming to professional attention involve situations of intimate partner violence. These cases fall into several patterns, the most common of which is long-term domestic violence, or “domestic violence grown old.” Brandl (2000) discusses this form of abuse that is “grounded in the abuser's need to gain and maintain control over victim – dynamics similar to those seen in cases of spouse abuse involving younger adults” (p. 39). Abusive spouses often justify forced sexual contact, rationalizing that sex is a normal and expected part of marriage. A sense of male privilege and a historically based view of wives as the sexual (and other) property of their husbands often contribute to rationalizations expressed by older batterers (discussed in Ramsey-Klawnsnik, 2003).

Illustrative Case #1:

(excerpted from Ramsey-Klawnsnik, 2003)

“Sixty-year-old Mrs. V. has been married for forty-one years, and is the mother of six children. She is diagnosed with clinical depression, onset during menopause. Her son sought assistance for her due to marital rape. During the Protective Service investigation, Mrs. V. acknowledged that throughout her marriage she had been repeatedly hit and forcibly sexually assaulted by her husband. There was also an extensive history of Mr. V. physically abusing the children. Although Mrs. V. had not been hit in many years, her husband continued to dominate her. She was distraught about the continuing marital rape. Among the tactics used by Mr. V. to control his wife were prohibiting her from driving, working outside of the home, or

managing money” (p. 46).

A second pattern of IPV cases coming to attention involves sexual abuse in a relatively new relationship. With increased life expectancy and changes in socialization patterns in recent years, older adults are increasingly engaged in dating relationships and remarriages following the death of or divorce from long-term spouses.

Illustrative Case #2:

(excerpted from Ramsey-Klawnsnik, 2003)

“Sixty-four-year-old Mrs. T. had been married for one year, following a month long courtship. Several months into the marriage, Mrs. T. reported to her physician that her husband repeatedly hurt her during sex. The physician prescribed a vaginal cream. Mrs. T. further explained that her husband forced her to engage in sex acts that she did not like. The physician advised, ‘just tell him no,’ and provided no further assistance. Several months later Mrs. T. sought help from the director of her senior center. She confided that her husband demanded sex on a daily basis and frequently bruised her by grabbing and forcing sexual acts. The director filed a Protective Service report (as required by law), which was investigated. During forensic interviewing, Mrs. T. reported that her husband had an explosive temper and his sexual aggressiveness had escalated in recent months. She was particularly upset to be forced into oral sex, and was quite anxious and fearful because her husband was threatening to force anal sex. Evidence present included a bite mark on her right breast and various thumb and finger imprint bruises on her arms, thighs, and buttocks. Mrs. T. regretted the marriage and contemplated leaving her husband, but worried about the many problems this would create” (p. 47).

A third but infrequent pattern observed is late-onset sexual abuse in a long-term relationship that has been non-violent. This is typically the result of age-related serious medical, cognitive, and/or psychiatric problems affecting the offender.

Illustrative Case # 3:

(excerpted from Ramsey-Klawnsnik, 2003)

“Mrs. E. is eighty-years old, has Parkinson’s disease, and uses a wheelchair. She weighs ninety-five pounds and is quite frail. She told her visiting nurse that she was worried

about her husband because he exhibited dramatic behavioral changes. These included accusing her of trying to poison him and forcing her into unwanted sexual intercourse. Mr. E. also refused to allow their adult daughter to visit, accusing her of stealing from him and trying to poison him. Mrs. E. reported that until recently her husband had been consistently loving and considerate, not abusive or suspicious. She believed that illness caused the strange behavior. He also experienced short-term memory problems and refused medical help... Through social services intervention, Mr. E. was involuntarily hospitalized for an evaluation. He was diagnosed with progressive dementia and several other major medical problems” (p. 47).

Incest

Offspring Offenders

The serious problem of incestuous abuse of children has been documented in the literature for some time and professionals have developed skills in responding. In contrast, most are not aware of incest affecting elderly individuals. It can be quite shocking and disturbing to encounter this problem.

Illustrative Case #4:

Mrs. Evelyn W. is an eighty-four year old widow who has a serious problem with her son, Lester. He is 53 years old and has always had difficulty coping with life. Throughout his adulthood, he has periodically lived with Evelyn. She finds his drinking and depression hard to tolerate. He does bizarre things – like the strange sexualized drawings with which he covered the walls of his bedroom. When drunk, hung-over, or angry, he walks around Evelyn’s apartment naked, masturbates in her presence, and makes sexually offensive and threatening comments. He is chronically unemployed and therefore she supports him on her limited fixed income causing her stress and sacrifice. She fears that he will become homeless or incarcerated. These fears, along with her embarrassment and maternal instinct to protect her offspring, prevent her from discussing with others the problems he creates or taking steps to put him out of her apartment.

One profile of elder incest offenders identified in the literature is,

“An adult child who is unmarried, unemployed or under-employed, and resides in the home of an elderly parent, financially supported by the parent. The adult child displays poor social, occupational, and financial functioning, and often, substance abuse or mental illness. As the parent becomes increasingly elderly and ill, she becomes more and more available to her poorly functioning offspring as a potential victim. It is not unusual to find a pattern of multifaceted abuse, which may involve neglect, psychological and physical abuse, financial exploitation, and in some cases, sexual abuse” (Ramsey-Klawnsnik, 2003, p. 50).

In some documented cases of incest involving elderly victims, perpetrators had histories of sexual aggression against individuals outside of the family and of younger ages.

Other family member offenders

Sons-in-law, grandchildren, siblings, nephews, and others have been identified as elder sexual offenders. The following case is an example that also demonstrates the range of abuses to which elders may be subjected.

Illustrative Case # 5:

(excerpted from Ramsey-Klawnsnik, 2003)

“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 undressed her, pulled back all bed clothing, and instructed Mrs. J. to open her legs and smile for the camera. He told her that he needed to take the photos, ‘so that no one will think that I abused you,’ and said that her daughter would want her to cooperate.

“Mrs. J. also reported that Charlie had ‘checked’ her genitals by pushing something large in and out of her vagina. While he did this he told her that she needed to help him climax. In addition, Charlie had forced her to sign papers without the opportunity to determine the content. During the Protective Services investigation, Mrs. J. was found to be credible. She was helped to move out of her son-in-law’s home and she cooperated when he was criminally

prosecuted. It was discovered that she had been forced to sign papers declaring Charlie her life insurance beneficiary. Involved professionals were especially concerned about this case because Charlie earned his living as a Home Health Aide” (p. 51).

Other Domestic Abuse

Unrelated individuals providing services to elders living in community settings may use the provision of those services as a means to accomplish abuse. Cases of ESA perpetrated by community care providers have been documented involving offenders that include volunteers, transportation services workers, certified home health aides, uncertified private pay helpers, and others. Elders who rely upon community services to meet their basic needs are especially vulnerable to this type of victimization.

Illustrative Case #6:

(excerpted from Chihowski and Hughes, 2008)

“Marjorie was active and independent and in her early 80’s. She experienced mild short-term memory difficulty and received transportation assistance for accessing food, medications and banking... Marjorie was referred to Adult Protective Services (APS) when she was diagnosed with a rib compression fracture that occurred when she received a strong hug from the driver. Marjorie disclosed to the APS investigator frequent hugging and inappropriate touching from this man in spite of her requests to stop. The driver had repeatedly suggested having sex and he had attempted to pull down Marjorie’s trousers” (p. 388).

Due to multiple factors, including her need for transportation to obtain basic necessities, Marjorie was reluctant to file a complaint against the driver with the senior services center that operated the van. Victims like Marjorie often fear that they will be disbelieved if they report sexual aggression by providers and that a consequence may be losing a necessary service.

Sexual Violence Perpetrated By Strangers and Acquaintances

Elders, like people of all ages, are also vulnerable to sexual assault perpetrated by strangers and acquaintances. In fact,

among 284 suspected elder sexual assault cases studied, 26% of the suspects were strangers to the victims and 7% were acquaintances that had no care provision relationship (Burgess, Ramsey-Klawnsnik and Gregorian, 2008). While these cases are not technically considered situations of elder abuse under definitions established by the NCEA (2007), the vulnerability of seniors to these assaults, and the harm that can result, are demonstrated by the following case. This case also reveals the potential for elders, especially those with disabilities, to be considered unreliable as reporters of sexual assault.

Illustrative Case #7:

(excerpted from Ramsey-Klawnsnik et al, 2007)

“Ms. P., a sixty-four-year-old woman with long-term schizophrenia, was admitted to a state mental hospital due to an episode of decompensation and active psychosis. The next day, she disclosed to a psychiatric nurse that just before her admission she was sexually assaulted by a neighbor. 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 and Adult Protective Services (APS). The R.N. requested that the physician order an exam by a Sexual Assault Nurse Examiner (SANE). The police initially believe the report to be without merit, however, DNA evidence was found during the exam. Additionally, the APS investigator who interviewed Ms. P. believed her to be credible in describing the recent rape by the neighbor. The police arrested the neighbor after a criminal records check revealed that he had a history of criminal conviction for sexual assault. While initially it appeared that a false abuse disclosure resulted from the psychotic episode, evidence revealed that in fact the sexual assault had triggered Ms. P.’s decompensation” (p.333).

Institutional Sexual Abuse

It is particularly alarming when elders living in care facilities are sexually assaulted. The reason for admission to a nursing home or other group care location is obviously special needs that ill or impaired people and their families are unable to meet at home. Elders in placement typically experience significant physical, cognitive, psychiatric

or other debilitating conditions. Placement involves the payment of substantial sums of money to the facility. In return, the facility and its staff are expected to provide humane quality care, including a safe living environment and protection from danger. As with child sexual abuse that occurs in institutions, facilities in which sexual assault of elders occurs frequently have not one, but often multiple victims. The two most commonly identified perpetrators in institutional sexual abuse cases are employees and residents.

Employee Perpetrators

Employee perpetrators have been found to include direct care providers as well as janitors, housekeepers, laundry workers, and others. When a sexual assault allegation arises against a facility employee, it is not unusual for management and other staff to be shocked and perhaps even prematurely conclude that the resident accusing the employee is not credible.

“Sexual offenders who find their way into employment within care facilities can be extremely manipulative and skilled at gaining the trust of supervisors, fellow workers, and vulnerable residents. Substantiated cases involving facility employees, including certified nursing assistants (CNAs) and janitors, who have sexually assaulted residents, reveal that these offenders can be well-liked, respected and trusted by other staff. They may even be regarded as exemplary employees, those who may volunteer for extra duties, night shift, and to handle the most difficult of residents. Typically, of course, these assignments lead to greater opportunity to be alone with the most vulnerable residents” (Ramsey-Klawnsnik et al, 2007, p. 334).

Decision-makers may be reluctant to believe that sexual assault has occurred, despite evidence of abuse. In the following case, facility management dismissed the resident’s complaint of sexual abuse perpetrated by an aide and did not report it to state officials as required by law. They continued to employ the alleged perpetrator and allowed him to care for people with significant disabilities and communication limitations. At that point, the victim felt pervasively unsafe and pleaded with her next-of-kin to remove her from the nursing home. She was removed and subsequently discussed the incident with a compassionate

home health aide assigned to care for her. The aide reported it to state officials, triggering an investigation.

Illustrative Case #8:

(excerpted from Ramsey-Klawnsnik et al, 2008)

“A male direct care provider employed in a nursing home was accused of digitally penetrating a resident. The female resident had suffered a stroke and was incontinent, yet mentally competent and able to communicate clearly. The resident reported to the facility management, a relative, and the investigator that the aide, who was not assigned to provide care to her, entered her room and forcefully inserted his fingers into her vagina causing her pain and soreness along with significant emotional distress. The investigator concluded that the resident was able to clearly articulate her experience of the event and was emotionally traumatized by it. The investigator further confirmed that the accused aide in fact had not been assigned on the afternoon in question to work on the unit that housed the alleged victim. The alleged perpetrator admitted to the investigator that he had entered the resident’s room and inserted his fingers into her undergarment, claiming that he needed to determine if she had urinated and required assistance. He denied that he penetrated the resident’s vagina and claimed that he was confused as to the unit on which he was supposed to be working on that day” (p. 370).

It was of clinical and forensic significance that this resident had lived in the nursing home for many months prior to the incident without making any complaints or requesting relocation. Research has found that it is not unusual for victims to attempt to leave facilities in which they have been sexually assaulted (Burgess, Ramsey-Klawnsnik and Gregorian, 2008). This suggests that an important intervention to offer institutional victims is assistance in relocating.

Resident Perpetrators

Facility residents who engage in sexually aggressive behaviors towards others sometimes have disabilities, including psychiatric illness or dementia, which impair their ability to self-regulate. Some have been prescribed medications that exacerbate impulse-control problems and increase

libido. Others have criminal histories, including sexual assault convictions (see Bledsoe, 2006). It is possible that some have undetected histories of sexual aggression. Regardless of the factors that contribute to their sexual offending, the harm that they inflict on fellow residents is often significant. Furthermore, a sexual offender residing in a care facility can easily find many potential victims who are vulnerable to being overpowered, given the profound disabilities often experienced by people needing institutional care.

Illustrative Case #9:

(excerpted from Ramsey-Klawnsnik et al, 2007)

“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. Numerous episodes of sexually offensive behavior towards other residents were charted. Mr. N.’s internist and treating psychiatrist were repeatedly notified of these incidents and the staff was instructed to provide constant supervision. The psychiatrist and his psychiatric nurse practitioner prescribed a variety of psychotropic medications attempting to control the behavior. Mr. N. was allowed to continue residence at the facility for over six months, during which time he sexually assaulted many female residents. Eventually, he was transferred to a more secure facility. Family members and guardians of several victims brought suit against the facility, the physicians, and the nurse practitioner for failing to effectively control the abusive and dangerous behavior of Mr. N.” (p. 333).

This case demonstrates the significant professional liability issues inherent in resident-perpetrated sexual abuse incidents in facilities. Responding to the sexual victimization of clients is discussed later on in this article, as well as in Ramsey-Klawnsnik et al, 2007.

Problems Confronting Victims

Problems confronting victims of ESA include those faced by sexual assault victims of other ages. These include feelings of shame and humiliation and fear of repercussions for disclosing abuse or seeking help. Often times, however, problems experienced by elderly victims of sexual assault are even more challenging. Given the social climate in which many seniors were raised, feelings of shame and self-blame for sexual abuse are often more intense than those felt by younger victims. As discussed by Vierthaler (2008),

“Today’s elder victims grew up on 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, and how society and professions dealing with crime victims respond to elder victims” (p. 309).

Victims of Abuse Within the Family

Elderly victims of long-term domestic violence often feel powerless to self-protect. When they were young, resources for battered women such as restraining orders, shelters, and other domestic violence interventions were not available and not considered necessary. Elders who were young, battered women fifty to sixty years ago were socialized in a climate that discriminated against women. At that time, there was little social support for women’s right to protection from domestic violence and no protection from marital rape under the law. Furthermore, individuals who have experienced decades of domestic abuse typically suffer extensive psychosocial and physical damage. This includes extensive deterioration of self-esteem and feelings of empowerment.

Elders assaulted by spouses as well as other family members including adult children or grandchildren face a host of problems.

“Victims of familial elder sexual abuse frequently rely upon their abusers for care and assistance... During later life, need for assistance generally increases. It is natural to prefer to receive help from family members rather than strangers. This interdependency makes victim self-

protection via separation from the offender quite difficult. Without separation, continued sexual abuse is likely... Assault is more psychologically injurious when inflicted by someone expected to provide love, protection, and support. Many elderly victims of familial sexual abuse experience powerful ambivalent feelings towards their abusers. These feelings complicate the trauma response, and make it difficult to accept intervention. Many victims fear that intervention will lead to negative consequences for their abusers - perhaps displacement from the home and consequent homelessness or even criminal prosecution and imprisonment. Familial bonds of attachment make it difficult for victims to trigger such consequences” (Ramsey-Klawnsnik, 2003, p. 57).

Response to Disclosures of ESA

As illustrated by some of the cases presented, many ESA victims have not been believed when they found the courage to seek help. In some cases, elders who disclosed have been presumed to be psychiatrically ill, rather than victimized.

Illustrative Case #10:

(excerpted from Ramsey-Klawnsnik, 2004)

“One woman stated that she had been sexually assaulted by a male resident of her assisted living facility while she attempted to open her mailbox. In response, she was diagnosed with paranoia, placed on psychotropic medication, and transferred to another facility. Subsequently, the identified offender was observed sexually assaulting a second female resident. She was afraid to discuss the episode when interviewed for fear she would be put out of her housing as the previous victim had” (p. 94).

In a study of sexual abuse in care facilities, five elders disclosed that they had been anally raped; yet civil abuse investigators substantiated only one of those cases. Similarly, five reported being vaginally raped, but only one resulted in substantiation. Four who reported that they had been digitally penetrated and two who stated that they were forced into oral genital contact were disbelieved (Ramsey-Klawnsnik et al, 2008).

Queried institutional abuse investigators reported that facility staff and administration have discredited residents who disclosed

sexual assault simply because those residents had disabilities (Ramsey-Klawnsnik and Teaster, 2008). Individuals who have psychiatric disabilities are particularly likely to be disbelieved when they report sexual assault. For example, in a study of 429 cases of alleged sexual abuse of vulnerable adults living in care facilities, about one-third of the alleged sexual abuse cases that occurred in nursing homes, assisted living facilities, and group homes were substantiated by state authorities. In contrast, only one of 48 alleged cases in state mental hospitals was substantiated (Ramsey-Klawnsnik, Teaster and Mendiondo, 2008). Another study reported that nursing home staff demonstrated a bias toward doubting disclosures of sexual assault made by residents who had dementia (Burgess, Dowdell, and Prentky, 2000).

Lack of Pathway to Help

A key resource for elders who are unable to independently seek help is someone who will report their victimization so that help can be obtained. Research interviews of abuse investigators found that delayed reporting of facility sexual abuse was a frequently cited problem. Those interviewed indicated that reporting delays often caused evidence to deteriorate or evaporate, thereby handicapping them from determining if sexual abuse had occurred and identifying victims (Ramsey-Klawnsnik and Teaster, 2008). Failure to report in a timely manner can result in continuing assaults. Delays also cause victims to wait for interventions including medical treatment for injuries, sexual assault counseling, and opportunity to talk with law enforcement officers.

It is hypothesized that many cases of ESA are never brought to the attention of those who can provide assistance. Burgess and Clements (2006) cite “reason to believe that nonreporting in cases of elder sexual assault may be extraordinarily high,” (p. 114).

Lack of Services Tailored to Elderly & Disabled Victims

A significant problem faced by victims of ESA is the lack of helping resources available to them even if their assaults are brought to professional attention. Vierthaler (2008) discusses the fact that services for victims of sexual assault have not been designed to accommodate the needs of older people,

“...while elder sexual assault victims may require more assistance and specialized help because of age-related disabilities and other factors, they often receive fewer services and intervention than younger victims” (p. 307).

For example, sexual assault centers typically require that victims travel to the center to receive counseling and other assistance. This is simply not possible for elderly victims who are seriously ill or disabled. Sexual Assault Nurse Examiners and other forensic evaluators are generally not trained to evaluate elderly victims (Burgess and Clements, 2006; Poulos and Sheridan, 2008). Courtrooms are often not accessible for severely impaired people. Legal procedures designed to hold perpetrators accountable are long and cumbersome, not conducive for elderly ill individuals who may not survive the many months that it can take to bring a case to trial. Age-related biases regarding the reliability of the testimony of older people can also interfere with victims receiving justice under the law. For a discussion of these and other legal and medical problems faced by elderly victims, see CDDA, 2003.

Research Findings

During recent years, the foundation of a scientific body of knowledge about the sexual abuse of elderly individuals has been built by research. This section will provide a compilation of emerging data.

Incidence/prevalence

Due to the lack of a national survey, estimates of the incidence and prevalence of elder abuse in general as well as any specific form of elder abuse are unavailable (Bonnie and Wallace, 2003). It is established that sexual abuse is the least frequently reported and substantiated form of elder abuse (National Center on Elder Abuse, 2006). Teaster et al (2006) found that nationwide 46% of reports of all forms of elder abuse are substantiated at the conclusion of Adult Protective Services investigations. The only study thus far to explore the investigation of reported institutional ESA, found that only 27% were substantiated (Ramsey-Klawnsnik et al, 2008). Substantiation rates for domestic ESA allegations have not yet been researched.

Social Work Roles Regarding Elder Sexual Abuse

- ▶ Plan and deliver elder care services aimed at preventing all forms of elder abuse;
- ▶ Detect situations of sexual violence against older people:
 - Recognize forensic markers
 - Screen for elder sexual abuse when indicated;
- ▶ Help to stop elder sexual abuse by reporting it to state officials;
- ▶ Collaborate with other professionals involved in victim protection;
- ▶ Advocate for victims and provide intervention services;
- ▶ Help victims process their trauma, reduce their vulnerability, recover;
- ▶ Help hold perpetrators accountable by responding to incidents of elder sexual abuse;
- ▶ Conduct or contribute to research regarding elder sexual abuse;
- ▶ Disseminate elder sexual abuse information;
- ▶ Contribute to the prevention of elder sexual abuse through all of the above.

While sexual abuse appears to occur less frequently than other elder abuse, clinical experience suggests that it is more hidden than other elder abuse. Physical abuse, neglect, and financial exploitation frequently result in readily visible evidence, unlike sexual assault. Shame and fear may result in more reluctance on the part of victims to disclose sexual assault rather than other assaults. Due to sexual assault myths and ageist beliefs, professionals and the public are more likely to overlook sexual abuse than other elder maltreatment.

Sexual assault of all age groups appears to be underreported, but there is reason to believe that older victims fail to come to attention more frequently than others.

“As with any rape case, sexual assault in older women is almost certainly underreported. The rates of dementia and disability in this age group provide additional challenges to the reporting of assault cases, as does the isolation of many elderly people” (Eckert and Sugar, 2008, p. 688.e1).

Victims

Ages

Studies of ESA have typically included victims aged 60 and over. Victims of a wide variety of ages have been identified. Alleged institutional victims were found to range from age 60 to 101 and had a mean age of 79 (Ramsey-Klawnsnik et al, 2008). Burgess, Ramsey-Klawnsnik and Gregorian report an age range of 60 to 100 among 284 domestic and institutional alleged victims.

The mean age was 78.4 and about one-third were in their 70's and one-third in their 80's. Contrary to common assumption, research obviously demonstrates that advanced age certainly does not protect one from becoming a victim of sexual assault.

Gender

Consistently, research has found the overwhelming majority of identified ESA victims to be female. However, male victims have been reported in almost every study. An early study of 28 alleged community cases found 100% of victims to be female (Ramsey-Klawnsnik, 1991). Holt (1993) reported 90 alleged ESA cases in Britain that occurred primarily in private homes and found that 86% of victims were female. A report of 20 facility victims found that 90% were female (Burgess, Dowdell and Prentky, 2000). Teaster and Roberto (2004) reported that 95% of 82 ESA victims (72% of whom resided in facilities) were female. In a study in which about three-quarters of the 284 incidents occurred in private homes, 93.5% of alleged victims were female (Burgess, Ramsey-Klawnsnik and Gregorian, 2008). Among 124 alleged sexual assaults of elders in facilities, 77% of the victims were female and the confirmed victims were 79% female (Ramsey-Klawnsnik et al, 2008).

A qualitative analysis concluded, “Like other forms of domestic violence, elder sexual abuse within the family tends to be primarily a problem of male violence directed against female victims” (Ramsey-Klawnsnik, 2003 p. 56). That analysis did report, however, that older men are occasionally identified as domestic victims.

As a whole, the studies suggest that sexual victimization of older men occurs more frequently in institutions than domestic settings. Perhaps this occurs because men in facilities generally experience more disabilities and health problems than men in the community. To illustrate, Teaster et al (2007) found that 26 male suspected sexual assault victims over the age of 50 in facilities tended to have cognitive and physical limitations that limited their ability for self-care.

It is possible that older men who are sexually assaulted are less likely to be identified than female victims due to gender biases. As an example, Ramsey-Klawnsnik et al (2008) report a case of alleged anal rape of a 65-year-old man by a facility direct care worker. The worker was also accused of burning the resident's arm. Despite medical evidence (a torn rectum in addition to serious burns), and the worker's admission of physical abuse and bruising the resident's genitals, only physical abuse was substantiated.

Disability & Dependency

Vulnerability to all forms of abuse rises dramatically for people who experience disabilities. Age-related health problems, including strokes and dementia, increase risk of disability during senior years. Conditions that cause individuals to be unable to care for themselves or communicate place seniors at elevated risk for all abuse, including sexual. Furthermore, people with dementia and psychiatric illness are unlikely to be considered credible if they disclose abuse. Ironically, conditions that elevate risk of assault also tend to impede victims from effectively self-protecting, seeking and receiving help, and cooperating with criminal prosecution of their offenders.

Teaster and Roberto (2004) found that among 82 elders confirmed as victims of sexual abuse by Virginia Adult Protective Services, most were women with cognitive, functional, and physical limitations who resided in nursing homes.

Among 124 facility ESA alleged victims, significant health conditions and disabilities were found:

“Alleged victims suffered from a number of illnesses, including dementia of the

Alzheimer's type (64%), heart disease (45%), diabetes (16%), Parkinson's disease (8%), cancer (3%), substance abuse (2%) and traumatic brain injury (2%). Diagnosed disabilities of the alleged victims were: cognitive (48%), psychiatric (40%), physical (38%), developmental (8%), and sensory (6%). Many victims were very dependent upon others as evidenced by the finding that 48% required assistance in all Activities of Daily Living. Only one-third ambulated independently and 17% were not ambulatory even with assistance. Only 3% were able to independently manage their financial affairs. The vulnerability of this group is also demonstrated by their communication limitations. Fewer than half communicated without difficulty, 4% were non-verbal but communicated through other means, and 7% were unable to communicate in any way" (Ramsey-Klawnsnik et al, p. 364).

Perpetrators

Ages

Studies have found that elder sexual offenders include children and those of advanced age. Over a third of the alleged perpetrators in a study of domestic ESA were elderly (Ramsey-Klawnsnik, 1991). Jeary (2005; 2004) reported 52 convicted elder sexual offenders ranging in age from 16 to over 70, with two-thirds under the age of 30. Morgenbesser, Burgess, Boersma and Myruski (2006) described 112 elder sexual assaults reported in news media accounts involving perpetrators ranging from 14 to 70 years. Two hundred thirty (230) alleged elder sexual offenders ranged from adolescents to elders, including four over the age of 90 (Burgess, Ramsey-Klawnsnik, and Gregorian, 2008). Ramsey-Klawnsnik et al (2008) described 119 alleged institutional elder sexual perpetrators with an age range of 19 to 96 with a mean age of 56. Confirmed reports of juveniles sexually assaulting grandparents also exist (see for example, Ramsey-Klawnsnik, 2003).

Gender

Studies have consistently found that the vast majority of identified elder sexual offenders are male. Female offenders, however, have been identified in both domestic and institutional settings. In a study of 28 domestic cases, alleged perpetrators were identified in all but one case. Twenty-six

cases involved male alleged perpetrators, and one case involved both a male and a female perpetrator (Ramsey-Klawnsnik, 1991). Among 230 alleged offenders, over 90% were male (Burgess, Ramsey-Klawnsnik, and Gregorian, 2008). Of 119 alleged facility perpetrators, 78% were male. Accused males were much more likely (31% versus 12%) to be confirmed as perpetrators than accused females (Ramsey-Klawnsnik et al, 2008).

Oliver (2007) reports that female sexual offending is under-recognized. He has found that female offenders that do come to attention rarely target adults, but usually assault child or juvenile victims. It is noteworthy, then, that 22% of the alleged perpetrators and 12% of the confirmed perpetrators were females in the National Institute on Aging funded study that analyzed elder sexual assaults in care facilities (Ramsey-Klawnsnik et al, 2008). Findings from all studies of ESA, both those of community and facility cases, are consistent in that female sexual offenders against older individuals are discovered much less frequently than are male offenders. Available research findings (Ramsey-Klawnsnik, 2003; Ramsey-Klawnsnik et al, 2008) as well as clinical findings suggest that female sexual offending against elders is more common in facility cases rather than in the community. However, situations of female sexual offending against older persons have been identified in the family and community. Harm that female offenders inflict on their victims can be severe in consequences as demonstrated by the following situation.

Illustrative Case #11:

(excerpted from Ramsey-Klawnsnik):

"Sixty-two year old Mrs. G.'s two adult sons, Tim and Robert, and Tim's girlfriend, Joyce, resided in her apartment. Joyce was treated for a diagnosed mental illness, and was also a substance abuser. Mrs. G. reported to her visiting caseworker that the previous night Joyce had been intoxicated, undressed in the living room, and approached Tim for sex. Tim refused. Joyce threw a chair at him, hitting him in the head. Joyce then demanded sex from Robert, and twisted and pinched his penis when he refused. Next, Joyce attacked Mrs. G. by pushing her down on her bed, getting on top of her, and biting her breast. Joyce gyrated her pelvic area against Mrs. G. in a sexual motion, and attempted to undress

Mrs. G. A physical struggle ensued, leaving Mrs. G. bruised and her shoulder injured. Joyce broke furniture and glass, and culminated the assault by running outside naked. Medical examination revealed a bite mark on Mrs. G.'s breast, and various bruises and lacerations resulting from the struggle. Mrs. G. and her sons obtained a restraining order against Joyce, who was arrested and charged with three counts of indecent assault, assault and battery of a person over sixty years with injury, and several counts of indecent exposure" (p. 52).

Characteristics

In a study of domestic cases, 81% of the alleged perpetrators provided some care to their victims and 78% were family members, predominately sons and husbands (Ramsey-Klawnsnik, 1991). Characteristics of offenders who sexually victimize elders within their own families were found to include mental illness, substance abuse, domineering or sadistic personality traits, sexual deviancy, and paternalistic views of wives as sexual property (Ramsey-Klawnsnik, 2003).

Burgess, Dowdell, and Prentky (2000) reported 18 offenders who sexually assaulted in care facilities including 15 employees and three residents. All were low in social competence, and victimized incapacitated residents.

An analysis of 125 elder sexual abuse cases found that 44% of the perpetrators were under the influence of drugs or alcohol at the time of the assault and that 44% engaged in multiple offenses (Burgess, Hanrahan, and Baker, 2005).

Jeary (2005; 2004) reported on 52 convicted elder sexual offenders. Their crimes were characterized by extreme violence. About one-third of the offenders had prior convictions for sexual assault, and half of those had previously assaulted elders. Twenty percent (20%) of perpetrators also had prior child sexual abuse convictions.

Morgenbesser, Burgess, Boersma and Myruski (2006) described 112 cases of elder sexual assault reported in news media accounts. Of 27 perpetrators whose occupations were known, all were employees or volunteers in the care facilities in which they assaulted elders. The authors discuss two types of elder sexual offenders: (1) predatory specialists who prefer older vic-

tims and (2) generalist predators that target victims of various ages.

Among 230 alleged elder sexual offenders about one-quarter were strangers to the victims, about one-quarter involved alleged incest, and 15% were spouses/partners. In 10% of cases the offender was an unrelated care provider. Six percent of the offenders who were co-residents with their victims in care facilities and 7% were acquaintances. Alleged female offenders included one unrelated care provider, two spouse/partners, and five other family members (Burgess, Ramsey-Klawnsnik, and Gregorian, 2008).

Among 119 alleged facility perpetrators, six had criminal histories, two had been previously accused of sexual assault, and six were substance abusers. The largest group, 43%, was facility employees, 41% were facility residents, and the remainder was family members and visitors of residents. Seventeen (17) of the 25 accused female perpetrators were employed as direct care workers in the facility. While 52% of the accused residents were confirmed as perpetrators, only 4% of accused employees were. The researchers hypothesized that resident perpetrators likely had lower social competence and ability to hide evidence of their sexual offending than employee perpetrators. It was also hypothesized that accused staff may have been offered more protections than accused residents prior to and during abuse investigations (Ramsey-Klawnsnik et al, 2008).

Consequences Faced

Studies have found consistently low rates of arrest and conviction of elder sexual offenders. None of the 32 confirmed sexual perpetrators in facilities was arrested, despite presence of compelling evidence in many cases (Ramsey-Klawnsnik et al, 2008). Burgess, Dowdell, and Prentky (2000) reported that 11 of 15 of sexually abusive facility employees were arrested but only five were convicted. National Institute for Justice funded research demonstrates that the older a sexual assault victim, the less likely it was that the offender was found guilty. Additionally, sexual assault charges were less likely to result in cases in which victims lived in assisted living facilities than when they lived independently (Schofield, 2006).

Signs and symptoms of ESA identified in research include a variety of physical indicators, socio-emotional and behavior signs, and statements by victims. Eyewitness reports of ESA also occur. A study of domestic cases (Ramsey-Klawnsnik, 1991) found that the most common indicators were physical injury (36% of cases) and victim statements (also present in 36% of cases). Physical injuries included repeated vaginal infections, bleeding, and tearing; genital scarring; and inflicted burns. Victim statements include direct disclosures as well as coded hints that sexual assault had occurred. Third party observation of sexual assault occurred in 32% of the cases. Symptoms of psychosocial distress including behavioral indicators of fear, anxiety and mistrust were present in 29% of cases. Suspicious behavior on the part of the alleged perpetrator (for example, statements indicating view of the elder as the sexual property of the alleged perpetrator) was witnessed in 25% of the cases.

Forensic markers of ESA found in a qualitative analysis of 100 cases that occurred in families (Ramsey-Klawnsnik, 2003) included verbal disclosures by victims, eye witness reports, and medical evidence consistent with sexual abuse including genital injuries, human bite marks, imprint injuries, and bruising on thighs, buttocks, breasts, and other areas. Spousal offenders who admitted their abusive actions and believed that their behavior was acceptable accounted for some cases being identified. Markers also included trauma symptoms in victims and unusual behavioral on the part of perpetrators such as an adult son sharing the bed of his elder mother who had dementia.

Ramsey-Klawnsnik, Teaster and Mendiondo (2008) analyzed 429 cases of alleged sexual assault of facility residents including both elders and adults with disabilities aged 18 – 59. Victim disclosure was the most common method through which sexual abuse of residents was discovered and occurred in 61% of the cases. This finding suggests that non-verbal individuals residing in facilities who are assaulted are at high risk of remaining unidentified as victims and unprotected from further abuse. This is very significant because facilities typically care for many individuals who are

unable to communicate due to conditions such as aphasia and advanced dementia. Other indicators found in this study were eyewitness reports (20%), statements of facility staff (16%), statements of other residents of the facility (9%), and other third-party statements (9%).

Among 284 alleged domestic and institutional cases, the following signs and symptoms were identified: witness to sexual victimization (43 cases), physical trauma (84), sexually transmitted disease diagnosis (6), shame or guarded response when questioned about possible abuse (19), fear or strong ambivalent feelings toward suspected offenders (49), victim upset during personal care (25). In 18 cases incidents of inappropriate boundaries between alleged offender and victim observed (18), suspected offender overly intrusive regarding provision of personal care (16), suspected offender made sexual statements regarding elder (29) and suspected offender displayed sexual behavior (30). Markers also included a care provider obsessed with an elder's bowels, an elder found genital bleeding, an elder's pubic hair dyed, an elder stating she was abused "down there," genital redness, semen odor on an elder who lacked capacity to consent to sexual activity, sperm in urine, and an elder expressing concern about sexually transmitted diseases (Burgess, Ramsey-Klawnsnik and Gregorian, 2008).

Burgess and Clements (2006) discuss the likelihood that medical evidence of ESA may be misinterpreted, causing cases of sexual assault to be missed by professionals,

"From a medical standpoint, bruising may be attributed to the aging process rather than to an assault. Medical personnel typically are not trained to evaluate elderly victims of sexual assault. One of the critical problems in the observation of genital injury in the elderly, for instance, is an understanding of the mechanism of injury. The most common explanation of genital bruising (and bleeding) in institutionalized elderly is either a 'botched catheterization' or 'rough perineal care.' Bruising to the abdominal area is often attributed to tight restraints for 'patient safety.' Clearly, there are many reasons to believe that the known cases of elder sexual assaults are underestimates of the true number of such cases" (p. 114).

Abuse Acts

A range of abusive acts against elders is reported in the literature. In addition to “hands-on” or touching offenses, the following have been cited: sexual harassment, threatening rape or molestation, forcing victims to view pornographic materials, using an elder to produce pornography, exhibitionism, and harmful genital practices.

Harmful genital practices are described as unnecessary, obsessive or painful touching of the genital area that does not occur as part of a medical or nursing care plan but is typically misrepresented by the offender as necessary for the benefit of the elder (Ramsey-Klawnsnik, 1996, 1991).

Illustrative Case #12:

(excerpted from Ramsey-Klawnsnik, 1998):

“Martha S. is eighty-seven years old. She is blind, and unable to walk or independently transfer herself from her bed to her wheelchair. Martha’s son, Albert, resides with her and assists her with many tasks. Adult Protective Services investigated possible physical abuse when a home health aide reported Martha bruised about the neck, shoulders, and arms. During the investigation, it was learned that Albert violently shook his mother, in his words “to calm her down”. It was also discovered that Albert routinely inserted a spoon and his fingers into Martha’s rectum, allegedly to stimulate bowel movements” (p. 10).

Among 33 confirmed elder victims in facilities, 20 were molested. Other abuses experienced by the elders included inappropriate interest in the victim’s body (12) and sexualized kissing (4). Two were exposed to exhibitionism, two had their breasts or buttocks exposed to others for the purpose of being humiliated, two were subjected to sexualized jokes and comments, two were sexually exploited, and two were forced to view pornography. One was anally raped, one was vaginally raped, and one experienced attempted vaginal rape. One elder was subjected to harmful genital practices and one elder suffered sadistic sexual behavior (Ramsey-Klawnsnik et al, 2008).

Harm Incurred by Victims

Physical Harm

Victims of ESA are often seriously harmed

by the acts perpetrated against them.

Eckert and Sugar (2008) evaluated 2399 female sexual assault victims including 102 over the age of 55. They found that genital trauma (including bruises, abrasions and lacerations) was more common in the older women than in younger victims and that older victims were more likely than middle-aged or young adult victims to be admitted to a hospital following sexual assault. Over one-third of the older victims experienced genital trauma, and intracranial injury was twice as prevalent in the older group compared to middle-aged victims. Almost 40% of the older victims experienced body trauma.

Poulos and Sheridan (2008) reviewed seven research studies that examined genital injuries in women after sexual assault. They concluded that genital injuries occur with more frequency and more severity in post-menopausal women than in younger women who are sexually assaulted.

Burgess, Ramsey-Klawnsnik, and Gregorian (2008) reported on 284 suspected victims of elder sexual assault. Over half of those examined had genital injuries including bruising, abrasions, redness, swelling, and perianal tears and 18% had anal injuries. More than 15% had throat or oral injuries, four died during their assaults and 6% required hospitalization in an intensive care unit as a result of sexual assault.

Physiological harm observed in elders residing in care facilities that had been sexually assaulted by other residents included urinary tract infections, genital redness and irritation, and bruising about the neck incurred during oral rape (Ramsey-Klawnsnik, 2004).

Older victims of sexual abuse within the family were found to display genital injuries, human bite marks, imprint injuries, and bruising on thighs, buttocks, breasts, and other body areas (Ramsey-Klawnsnik, 2003).

Psychosocial Harm

Burgess, Ramsey-Klawnsnik, and Gregorian (2008) reported that among a group of 284 suspected and confirmed sexual assault victims ranging from age 60 to 100, post-abuse behavior demonstrated that the victims experienced psychosocial trauma regardless of whether or not they could verbally discuss the event(s). There was no

significant difference between elders with and without dementia in post-abuse distress symptoms. The researchers reported a long list of observed post-abuse trauma symptoms including sleep disturbances, incontinence, increased anxiety, crying spells, withdrawal, depressive symptoms, startle reflex, agitation, restlessness, decreased enjoyment in social activities, intrusive memories, and attempts to leave care facilities in which they had been sexually assaulted.

Evidence of post-sexual abuse psychosocial trauma experienced by older victims of resident-perpetrated sexual abuse in care facilities has been found to include: reluctance to be bathed, pre-occupation with locking doors to keep other residents out, wearing multiple layers of clothing to cover and protect the body, withdrawn behavior, symptoms of depression, and flashbacks of childhood sexual abuse following sexual assault in later years (Ramsey-Klawnsnik, 2004a).

Beyond the direct physical and emotional harm that can result from elder sexual assault, evidence reveals that being abused during later life leads to earlier mortality. Lachs et al (1998) found that experience of any form of elder abuse is correlated with shorter survival even after adjusting for other factors associated with increased mortality in older adults. The authors conclude that elder mistreatment confers additional death risk.

Professional Roles and Responsibilities

Avoiding Harm and Protecting Elders

Unfortunately, in many documented instances, professionals have acted in ways that have harmed victims of ESA. Consider the following cases (described in Ramsey-Klawnsnik, 2004a, p. 94):

“In one facility an aide reported observing a male resident engage a woman with advanced dementia in sexual activity. The aide was told by her supervisor that, ‘residents have rights’ and she should ‘leave it alone.’”

“At a sing along conducted by the activities director of a facility, a male resident insisted upon sitting next to a particular

woman and holding her hand. She pulled her hand away, making it clear that she did not wish physical contact with him. After being chastised by the activities director to be friendly and hold the man's hand, she complied. This occurred despite the fact that several aides had previously reported observing this man take sexual advantage of the woman, including forcing her to hold his penis."

Actions that complicate the problems experienced by victims include missing or misinterpreting markers of sexual assault, refusing to believe abuse disclosures, contaminating evidence of sexual assault, failing to seek timely and appropriate help for victims, minimizing abuse experienced by seniors and the harm sustained, and failing to protect victims and potential victims under one's care. As an example, consider the actions of the physician who prescribed a vaginal cream to Mrs. T. and told her to "just say no" to her sexually abusive husband (illustrative case #2). His negligent actions caused her to experience additional months of marital rape until she found the courage to disclose to another professional. Fortunately, when she shared her situation with the social worker directing her senior center, appropriate intervention was provided and Mrs. T. eventually escaped the abusive marriage.

Armed with professional skills and relevant information, social workers are in a unique and excellent position to help protect older adults from sexual violence and to assist those who have been victimized. This section will discuss accomplishing these tasks.

Preventing Elder Sexual Abuse

Preventing sexual victimization of people who are elderly and/or have disabilities can be accomplished by the concerted efforts of social workers and professionals from other disciplines.

Employing Elder Care Providers

There are many ways that social work professionals can work to prevent ESA and minimize opportunity for sexual offenders to access vulnerable older people. For example, those that practice, administrate, or consult in long-term care facilities can contribute to the planning and delivery of care in ways that minimize opportunity

for sexual offending. As demonstrated by the research, failing to do so can have extremely harmful results.

When recruiting and interviewing potential employees and making employment decisions, care must be taken to screen out abusers and employ only individuals motivated to create safe environments for residents. Policies and practices that involve careful and thorough screening of applicants help to avoid hiring sexual offenders. Necessary steps include criminal record and background checks, conferring with those providing references, determining that information provided by potential employees is truthful, and diligent interviewing of candidates. Those who hire employees providing services to elders in community settings must also take these steps.

Training and Supervising Elder Care Employees

Planning and delivering safe care to vulnerable elders involves implementing training and supervision methods that minimize opportunity for abuse. Policies should also maximize the likelihood that if abuse occurs, it will be quickly noticed, reported, and stopped. Information about elder abuse in all its forms should be included in new employee training. Employees must be trained to recognize forensic abuse markers and immediately report all suspected situations of abuse so that screening can occur.

Making Care Facility Referrals and Placements

Hospital social workers, Adult and Elder Protective Services workers, and other aging services workers routinely refer elders to care facilities. Complex ethical issues are raised when seniors needing placement in care facilities have histories of physical and/or sexual aggressiveness. Issues to consider when referring or placing an older offender include: (1) insuring that the facility can provide effective care and supervision to that individual, and (2) informing the facility of the elder's special need for supervision and history of interpersonal violence. Bledsoe (2006) discussed problems involved when convicted sexual offenders become residents in care facilities. He reported that there were 795 registered sex offenders living in nursing homes in

2005. The US Government Accountability Office (GAO) (2006) estimated that 700 registered sex offenders lived in nursing homes or Intermediate Care Facilities for Mental Retardation (ICFMR) during 2005. Readers are encouraged to seek legal and ethical consultation when these complex referral matters arise.

Those who screen and make decisions to accept facility residents must be aware of the potential sexual and physical aggressiveness and take steps to minimize danger to those residing in the facility. Complex clinical and ethical challenges are faced by social workers and other professionals practicing in care facilities. Important among them is the duty to plan and provide care and supervision of residents in such a way that the safety of all is protected.

Similar issues confront social work staff practicing in community settings. For example, older individuals attending Adult Day Health programs serving people with dementia must be carefully supervised to minimize opportunity for harm to participants.

Detecting Elder Sexual Abuse

The detection of cases occurs when knowledgeable individuals recognize abuse signs and symptoms and skillfully screen for maltreatment when indicated. Practitioners across settings need to be able to recognize and act on the forensic markers of elder sexual abuse. Social workers often provide new worker training as well as continuing education to aging services staff. Many supervise staff. Employees must be educated about elder abuse and neglect, residents' or consumers' rights, and the duty to take seriously and report all disclosed and suspected victimization. Education must include material concerning the potential for sexual and other abuse of elders, including signs and symptoms and appropriate response to suspected cases.

Avoid Misinterpreting Markers

It must be recognized that an elder's disclosure of sexual assault does not, in and of itself, constitute evidence of paranoia or psychosis. This is especially relevant to clinicians who conduct mental health evaluations. Professionals who provide collateral input to evaluations and conduct geriatric psychosocial assessments

must also be aware of this. All sexual abuse disclosures made by elders must be taken seriously, reported, and carefully investigated. Harmful consequences that can occur by misinterpreting disclosures as evidence of psychiatric illness are illustrated by previously provided case examples #7 and #10. This has occurred in both institutional and domestic cases, and has not been limited to discrediting elders believed to be psychiatrically ill. Another problem is misattributing sexual abuse disclosures to the effects of dementia.

Illustrative Case #13:
(Excerpted from Ramsey-Klawnsnik, 2003):

“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” (p. 50).

Practitioners must also be aware of the potential to misinterpret physical evidence of sexual abuse. Elders presenting with physical injuries should be gently questioned about the cause, offered medical evaluation and treatment and other interventions as appropriate. Trainees, supervisees, and fellow professionals must be cautioned against prematurely concluding that physical injuries to elders are necessarily the result of age-related decline or accidents.

Screening for Elder Sexual Abuse

Social workers who become aware of possible sexual abuse of elderly clients need to be prepared to screen for abuse. This involves asking open-ended questions such as,

“Have you been hurt?”

“What happened?”

“How can I help you?”

“Are you in danger?”

“Are you afraid of anyone who lives with you or provides you assistance?”

Screening for abuse involves asking preliminary questions to determine an immediate course of action. Screening is also a process of gathering information to make an informed report to authorities as required by law. Information that emerges

in response to screening questions enables social workers to take other necessary steps to protect victims. These may include referring for medical and/or forensic evaluations and offering elders protection from contact with alleged perpetrators until the matter can be properly investigated. Professionals screening for sexual abuse should avoid contaminating or destroying potential evidence of assault. They must also avoid interviewing alleged perpetrators or pressuring alleged victims in any way, as well as other actions that may inadvertently increase danger to victims. Additional guidelines are provided in Brandl et al, 2007.

Reporting Suspected Elder Sexual Abuse

Social workers help to stop abuse by reporting suspected cases to state officials as required by law and making other appropriate referrals. In most states, social workers and other professional service providers are required by law to report all suspected elder abuse, including sexual abuse. In Massachusetts, licensed social workers are required by law to report suspected elder abuse. It is important to note that, “The existence of a social-worker client privilege or patient-psychotherapist privilege relating to the exclusion of confidential communications shall not prohibit the filing of a report” (651 CRM, p. 81). Practitioners are urged to learn and comply with the laws regarding reporting elder abuse that apply in their jurisdictions and to seek legal consultation as needed.

Consequences of Failure to Report

Unfortunately, the error of presuming that Mrs. M.’s statement was due to dementia (illustrative case #13) was compounded by the failure of both nurses and social workers to report the case, even after molestation was witnessed. Repeated episodes of sexual victimization occurred before authorities learned of the case and stopped the abuse by obtaining a court order. During this time, other residents in the facility in addition to Mrs. M. were vulnerable to sexual assault by her son.

Clearly, delayed reporting and failure to report suspected sexual abuse results in potential harm to victims including ongoing assaults, and lack of needed services. It also raises professional liability issues.

Practitioners should seek clinical and legal consultation as needed.

Investigating Suspected Elder Sexual Abuse

Many social workers are employed in positions in which they are responsible for conducting or supervising investigations of alleged elder abuse, including sexual abuse. Those holding positions with Elder or Adult Protective Services investigate domestic and/or institutional cases, depending upon jurisdiction. Department of Health employees and those working for other regulatory or licensing bodies investigate institutional alleged abuse.

Investigating all forms of victimization against individuals who are elderly or disabled is challenging. This function requires well-developed forensic and clinical skills, as well as in-depth knowledge of regulatory requirements and procedures. Discussing investigation principles and techniques is beyond the scope of this article. These issues are carefully discussed, however, in Chihowski and Hughes, 2008; Ramsey-Klawnsnik, 2005 a and b, 2004 a, b, and c, 1995, 1993 and Ramsey-Klawnsnik and Klawnsnik, 2004. Additionally, the National Adult Protective Services Association (www.apsnetwork.org) provides resources for investigators. It is important that professionals who are not authorized and trained to investigate alleged abuse refrain from attempts to do so. When well-intended but untrained and unauthorized persons attempt to investigate, disastrous consequences can result.

Providing Intervention Services

The best response to victims of ESA occurs when there is collaboration among the involved professionals: social workers and other social service and mental health staff, health care providers, law enforcement officers, domestic violence and sexual assault advocates, and court personnel. Collaboration and the team approach to helping victims are discussed in Brandl et al, 2007.

It is crucially important that victims of alleged sexual assault who are elderly are offered the opportunity to receive timely, unbiased, and qualified sexual assault

forensic examinations. Social workers must make referrals for Sexual Assault Nurse Examiner (SANE) Programs and related services, keeping in mind the time-sensitive nature of forensic procedures. Workers must also avoid actions that cause evidence of sexual abuse to deteriorate. For example, social workers practicing in nursing homes should educate staff that potential victims of sexual abuse should be referred for forensic evaluations immediately. Alleged victims should not be bathed and clothing and bed linens should not be laundered prior to evidence collection.

Another important part of intervention is supporting elderly victims during civil and criminal abuse investigations and criminal prosecutions. Social workers may also play important roles in contributing information to investigators.

Intervention may involve helping victims to access court orders designed to increase safety. Protective orders may be obtained on behalf of victims who lack mental capacity. Other court interventions including restraining orders and no abuse orders may be appropriate. Use of court interventions for protection of victims of elder abuse is discussed in Heisler, 2000 and Steigel, 2000.

Professionals involved in domestic violence, sexual assault, victim witness advocacy, shelters, and other victim services must be sensitive to the special needs of elderly individuals. Accommodations that may be required to meet these special age-related needs are discussed in Brandl, 2000; CDDA, 2003, Vierthaler, 2008, among other sources.

Those providing clinical treatment can be of great assistance to victims by helping them process their abuse, recover from psychosocial harm experienced, and implement self-protection measures. Professionals treating older sexual abuse victims must understand the complex and ambivalent trauma reactions typically experienced and the web of forces that may inhibit them from self-protecting and seeking help. Chihowski and Hughes (2008) discuss these issues, as well as the challenges that often confront professionals involved in elder sexual abuse cases.

Brandl (2000) discusses intervention in long-term domestic violence. She stresses

that the primary focus of the work must be victim safety. Key goals are breaking the victim's isolation (and hence dependence upon and vulnerability to the perpetrator) and holding the perpetrator accountable. Accomplishing the later requires social work collaboration with the criminal justice system. Restoring the victim's power and control is essential to effective intervention. Referral to services and resources are steps to breaking the isolation. Shelters, telephone hotlines, domestic violence and sexual assault crisis centers, home health services, senior centers, individual and group treatment are some of the many services that may prove helpful. Obviously, service recommendations will be tailored to the functional, cognitive, and psychosocial state of the victims, along with the wishes of that person.

Social workers may also be involved in the treatment and management of sexual offenders.

Among the many issues to keep in mind during intervention are cultural considerations and ethical principles. Ethical principles that can be particularly relevant to these cases include the older client's right to self-determination, right to the least intrusive intervention, and right to privacy and confidentiality.

Additional concerns that may confront professionals during elder sexual abuse intervention are the need to avoid over- or under-reacting to the client and his or her situation, potential complex counter-transference issues, and the need to avoid age-related discrimination in providing services.

Research

There has been markedly increased recognition of elder sexual abuse in recent years and a corresponding rise in research exploring this phenomenon. There remains much to be learned, however, regarding victims and perpetrators of sexual violence against elders and how this serious form of interpersonal violence can be best prevented and handled. Social work researchers can consider undertaking projects that expand the body of scientific information regarding all forms of victimization of older adults. As our demographics change and increased percentages of our population constitute those over the age of 60, it will be critically

important that reliable research findings inform abuse-related policy and practice, including the allocation of state and federal funds and program planning.

Social workers engaged in funding or overseeing research include those employed by state and federal agencies and private foundations. They must understand and act on the importance of supporting projects aimed towards better understanding of the victimization of seniors.

Professionals administering programs that collect case information can also help expand scientific knowledge by making data available to researchers with due precautions for privacy and protection of human subjects.

Dissemination of ESA Information

Dissemination of information regarding sexual and other forms of elder abuse to students, supervisees, trainees, colleagues, superiors, and professionals of other disciplines is also an important social work function.

Conclusion

There is a risk of ESA when others have power and control over vulnerable older adults.

“A civilized society certainly must take all possible measures to understand the sexual victimization of its most vulnerable citizens, prevent the occurrence of this type of crime, and respond ethically, humanely, swiftly, and effectively when it does occur” (Ramsey-Klawnsnik et al, 2007, p. 339).

A critically important safeguard for potential victims of ESA is a body of scientifically gathered information, knowledgeable professionals, and practices designed to enhance the safety and dignity of older adults regardless of their care needs and living situations.

It is imperative that helping professionals be able to recognize forensic markers of sexual abuse and all forms of elder victimization and be willing and able to respond appropriately to suspected cases. Informed professionals can contribute to the building of safe communities and care facilities for seniors. ❖

Brief author bio:

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Resources

Massachusetts Elder Abuse Hot Line:

1-800-922-2275

Massachusetts Executive Office of Elder Affairs Protective Services Program:

www.mass.gov

National Adult Protective Service Association (NAPSA):

www.apsnetwork.org

Phone: (217) 523-4431

Fax: (217) 522-6650

S. Spring Street, Suite 1200

Springfield, IL 62704

National Center on Elder Abuse (NCEA):

www.ncea.aoa.gov

National Clearinghouse on Abuse in Later Life (NCALL):

www.ncall.us

307 S. Paterson St. #1

Madison, WI 53703

Phone: (608) 255-0539

Fax: (608) 255-3560

National Committee for the Prevention of Elder Abuse (NCPEA):

www.preventelderabuse.org

1612 K Street, NW

Washington, D.C. 20006

(202) 682-4140

(202) 223-2099 (fax)

National Sexual Violence Resource Center

www.nsvrc.org

123 North Enola Drive

Enola, PA 17025

717/909-0710

877/739-3895 Toll Free

April 2009 FOCUS Homestudy Course
Elder Sexual Abuse POST-TEST

Circle correct answer.

1. Which of the following is true?

- a) Research has determined that elder sexual abuse is a rare occurrence compared to sexual victimization of younger age groups.
- b) Social workers who practice in a variety of direct service settings, as well as those engaged in education, administration, policy, planning, and research can contribute to the effective prevention of and intervention into elder sexual abuse.
- c) Both A and B are true

2. Sexual offenders who aggress against older adults

- a) Range from juveniles to elderly individuals
- b) Are typically adults ranging in age from 30 to 55
- c) Are primarily older individuals
- d) Do not include juveniles.

3. Research found that the most common way in which elder sexual abuse (ESA) of residents in care facilities was discovered was:

- a) Presence of sexual transmitted diseases among victims
- b) Eye witness report of sexual assault
- c) Victim's disclosure of sexual assault
- d) Genital injuries in victims

4. In terms of elder sexual abuse victims,

- a) Only female victims have been identified
- b) The vast majority of identified victims are female
- c) More male victims have been identified in institutional than domestic cases
- d) B and C

5. In terms of elder sexual abuse offenders

- a) The vast majority of identified offenders are male

- b) Female offenders have been identified but only in institutional cases
- c) Female offenders have been identified in both domestic and institutional cases
- d) A and C

6. Genital trauma in response to sexual assault

- a) Has not been studied in older victims
- b) Is more likely in older than younger victims
- c) Is more likely in younger than older victims
- d) Is not related to the age of the victim

7. Which of the following is true?

- a) Victims of ESA who have dementia have not been shown to demonstrate evidence of psychosocial trauma following sexual assault, most likely due to the fact that they cannot remember or describe the abuse.
- b) Research has found that ESA victims who have dementia demonstrate behavioral evidence of psychosocial trauma whether or not they are able to discuss the abuse.
- c) Elders who have dementia are rarely sexually assaulted and therefore their reaction to sexual victimization has not been studied.

8. Which of the following is true?

- a) Elders who have psychiatric disabilities are at risk of not being believed when they disclose that they have been sexually abuse.
- b) Elders with psychiatric disabilities are more likely to report that they have been sexually abused than elders who are not mentally ill.
- c) Elder sexual abuse victims who have psychiatric disabilities have not been included in research studies.
- d) A and B

9. Licensed social workers in Massachusetts

- a) Are duty-bound to protect the confidentiality of their clients and this overrides the mandate to report alleged elder sexual abuse
- b) Must decide on a case-by-case basis whether to report suspected elder sexual abuse to state authorities depending upon the needs and wishes of the involved victim
- c) Have a legal duty to report suspected elder sexual abuse that overrides a client's right to confidentiality

10. Problems faced by older victims of sexual assault often include:

- a) A lack of services tailored to the needs of older adults.
- b) Disbelief when they disclose their victimization.
- c) Intense feelings of shame, self-blame, and powerlessness.
- d) All of the above.

11. Sexual assaults against elders

- a) Range from non-touching offenses such as sexual harassment and threats to brutal attack
- b) Rarely leave medical evidence because the most common abuse act is molestation
- c) Are more likely to cause physical harm than assaults against younger victims due to age-related physiological changes
- d) A and B
- e) A and C

12. Social workers who discover that an elderly client has possibly been sexually abused should

- a) Commence an investigation to determine if a mandated report of abuse is required
- b) Inform the alleged perpetrator to put that person on notice that professionals are suspicious of abuse and the situation will be monitored
- c) Gently ask the elder open-ended

questions to screen for abuse and determine an immediate course of action

- d) Instruct the elderly client that a forensic abuse examination is required

13. Professionals who confront situations of possible elder sexual abuse and are in doubt as to the best course of action should

- a) Ask the involved elder how to proceed
- b) Seek clinical supervision and/or consultation
- c) Consider seeking legal consultation if indicated
- d) B and C

14. When a social worker providing services in a facility receives a referral requesting placement in that facility of a person with a history of sexual offending, the worker should

- a) Refuse to accept that individual
- b) Not accept the referred individual unless a plan for careful supervision and management is created that will ensure the safety of other residents
- c) Arrange to house that elder in a room with another aggressive resident
- d) B and C

15. Residents in care facilities that sexually abuse others placed there

- a) Have long histories of sexual offending
- b) Have undocumented histories of sexual offending
- c) Have psychiatric or cognitive disabilities that contribute to sexual offending
- d) All of the above are possible

Congratulations!
You have just completed the Post-Test for this CE Course!
Please fill out the Evaluation form and send both pages along with your payment to NASW-MA.

COURSE EVALUATION

Please indicate whether the following learning objectives were achieved:

1. Readers will learn five (5) types of elder sexual abuse cases identified in clinical practice.

Achieved in full 5 4 3 2 1 *Not Achieved*

2. Readers will learn five (5) research findings regarding sexual violence perpetrated against older adults.

Achieved in full 5 4 3 2 1 *Not Achieved*

3. Readers will learn three (3) responsibilities of social work and related professionals in regard to situations of elder sexual abuse encountered in practice.

Achieved in full 5 4 3 2 1 *Not Achieved*

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