



Pennsylvania Commission on Crime and Delinquency

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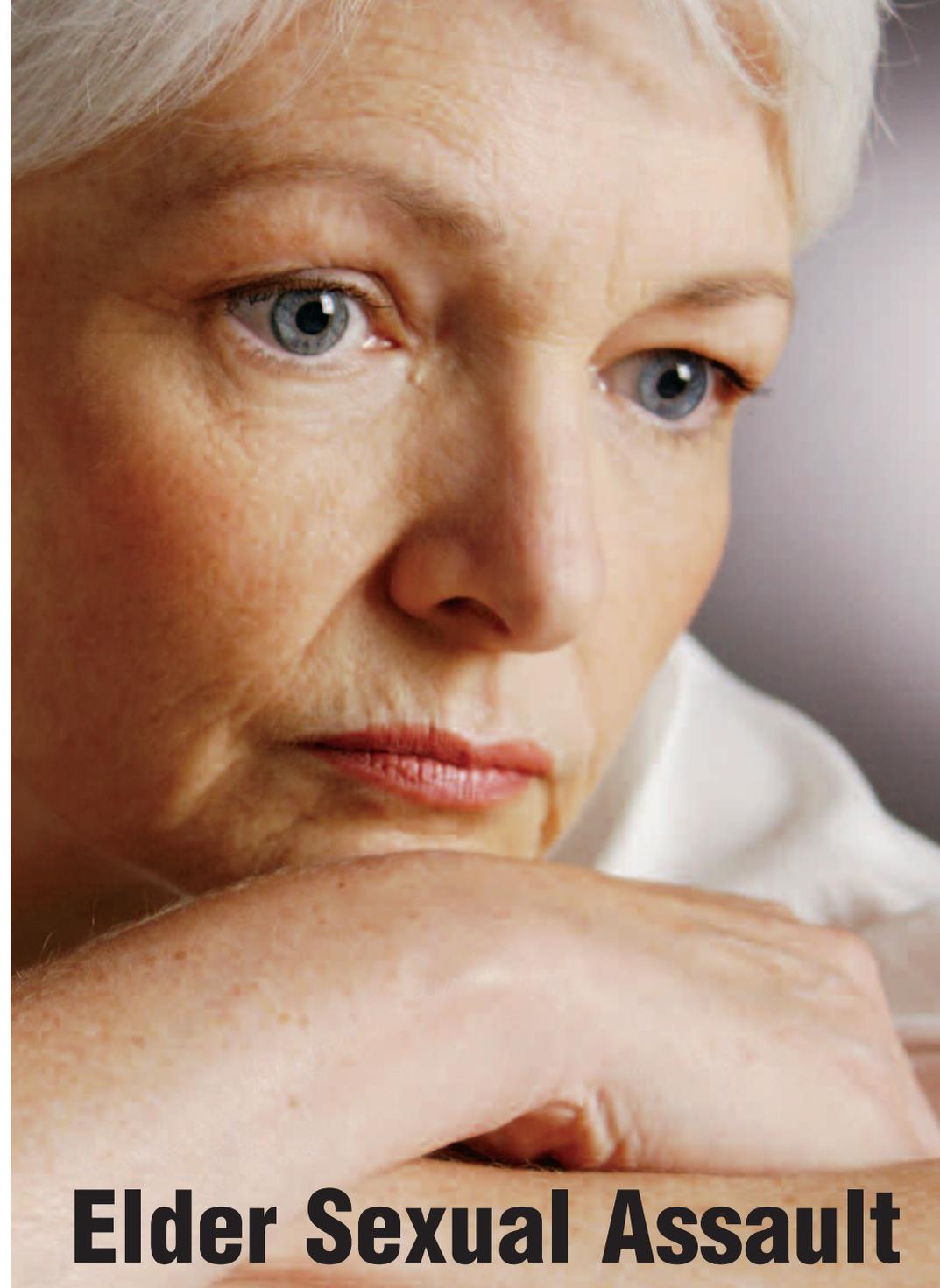
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Elder Sexual Assault

**Technical Assistance Manual
for Pennsylvania's Sexual Violence Centers**

Ann Burgess... Contributing Author

Ann Burgess, R.N., D.N. Sc. is one of the most accomplished nurses in North America. Currently Professor of Psychiatric Mental Health Nursing at Boston College, she is the former van Ameringen Professor of Psychiatric Mental Health Nursing at the University of Pennsylvania School of Nursing.

Dr. Burgess co-founded one of the first hospital-based crisis intervention programs for rape victims at Boston City Hospital in 1972. Research at that program introduced the Rape Trauma Syndrome in 1974. This diagnosis has since gained admissibility in over 300 appellate court decisions.

Dr. Burgess has long since expanded her research interests to explore the use of children in pornography; heart attack patients and the return to work; sexual abuse and patterns of crime scenes; children as witnesses in child sex abuse trials; AIDS, ethics, and sexual assault; sexual abuse and exploitation of children; and infant kidnapping. Most recently, she has been studying patterns of trauma in elderly and handicapped rape victims and testing interventions for reducing post-trauma symptoms in rape victims.

Author of nine textbooks on psychiatric nursing and crisis intervention, Dr. Burgess has also authored ten books on assessment and treatment of child, adolescent, and adult sexual assault victims and serial offenders, including rapists, murderers, child molesters, and abductors. This includes the award winning *Crime Classification Manual*. She has co-authored over 135 articles and chapters in rape victimology, as well as six monographs for the Department of Justice on child sex rings, adolescent rape victimization, adolescent runaways, child molesters and abductors, juvenile prostitution, and infant abductions. She has maintained a private psychotherapy practice in the Massachusetts area since 1966.

Dr. Burgess was recognized in 1994 for her continuing achievements and contributions by election to the Institute of Medicine, a part of the National Academy of Sciences. In 1996, she chaired the National Research Council's Task Force on Violence Against Women.

Her continued commitment to research and investigate matters of sexual and violent crimes keeps her at the forefront of these issues, pushing the limits of mental health's appreciation for offenders and their victims.

to try to understand the avenues of communication in people with cognitive problems because they assume the elder does not understand.

Develop a system of communication whereby the elder can tell you "yes" or "no." Once established, one can try to work with the victim. Use comforting measures such as positioning pillows and adjusting covers. Talk in a soft, soothing voice but be sure the elder can hear. Avoidance of what happened is not a comfort. It is not necessary to dwell on it but address it. Suggestions are to say, "I know something happened to you; that you were hurt on your body. Can you show me or tell me about it?" It is critical to emphasize the person who hurt them has been taken away; that he or she is now safe. The sensory link is important to establish. Say, "I want to try to understand and talk with you the best way you can. Squeeze my hand if you understand. Nod or blink your eyes to let me know you understand."

Consistency of visits is important. Try to schedule the visit to the nursing home at a consistent time each visit. Short frequent visits are most therapeutic. Try to visit when the elder is not receiving nursing or other services. Avoid nap times. If no one is available on staff to visit a victim in a nursing home, refer to visiting nurse association who can provide a geropsychiatric nurse specialist for consultation and guidance.

(Dr. Ann Burgess for PCAR, 2004)



All copy within this document that appears in a teal box has been written by Dr. Ann Burgess for PCAR.

Nursing Home. Three common nursing home sexual abuse victim profiles include: 1) physically disabled older resident, 2) cognitively impaired nursing home resident, and 3) physically impaired younger resident. The physically disabled older resident has no cognitive or mental impairment but requires assistance with mobility. The assistance may be short-term such as needing rehabilitation following surgery or long-term as in residents with complications from a stroke. The cognitively impaired resident has a primary diagnosis of Alzheimer's disease or other dementia and the physically impaired younger resident may have a physical impairment due to a chronic neuromuscular disorder such multiple sclerosis or amyotrophic lateral sclerosis (also known as ALS or Lou Gehrig's disease), or an impairment as a result of trauma from a motor vehicle accident or gunshot wound.

Nursing homes are, for the residents, precisely that – a home, and that the staff function as the resident's caregivers (in both a literal and figurative sense). The nursing home and its staff are perceived as "safe" and violations represent a more profound betrayal of trust than violations committed outside the sanctity of the home. (Ann Burgess for PCAR, 2004)

Nursing homes

Elder sexual abuse is most often being reported in nursing homes, by both employees and residents as perpetrators. While research has found varying results as to whether or not sexual abuse occurs 4.5 percent of those 65 and older are in nursing homes. 1.1 percent is between 65 and 74, 4.7 percent are between 75 and 84, and 18.2 percent are 85 and older. While abuse is certainly happening in other care facilities and the community, this section is designed to help the advocate understand the culture of nursing homes since they tend to house the most vulnerable of elders.

U.S. Department of Commerce. U.S. Census Bureau. "The 65 Years and Older Population: 2000. Census 2000 Brief." October 2001.

Suggested Approaches to Elder Victims in Nursing Homes

Rape crisis services are much more difficult to provide for the physically handicapped and/or cognitively compromised patient. The critical first step to a traumatized elder in a nursing home is to try to establish contact and trust using a soothing approach and voice.

Talking therapy is usually not the treatment of choice. Expressive therapies, including music therapy and drawing, may be more useful to calm a frightened and anxious elderly resident. The elder's favorite music tapes played on a cassette can be soothing and calming during a 30-minute session with an elder victim. Just sitting quietly with the elder shows safety, compassion, and concern.

Do not avoid expressing you know something happened to the elder. Even if the victim has serious cognitive deficits as through a stroke, do not assume she does not understand. Staff sometimes fail

A 41-year-old man entered the unsecured door of an assisted living facility and raped an 83-year-old woman in her room. The woman reported she was awakened to the man being in her room and that he stated, "Don't scream or I am going to kill you." She further stated that he held her down and assaulted her, taunting her, and ordering her to use profanity. She refused. After the assault, the man ran into a facility employee and asked her to help him find a friend who he said worked at the facility. He then put his hand over her mouth and wrestled her to the ground, grabbing her checkbook. He escaped and the employee called 911. The police arrived at 2:45 a.m. and found the perpetrator a few blocks away. When shown videos of himself at the facility, he admitted he entered the premises to sexually assault someone. The victim's son reported that his mother's personality changed after the attack. She became withdrawn and reclusive, the opposite of her pre-assault life style.

Introduction

Recognizing that the unique needs of senior victims of sexual violence are not being met, the Pennsylvania Coalition Against Rape (PCAR) and the Pennsylvania Department of Aging partnered to administer a grant from the Pennsylvania Commission on Crime and Delinquency to create an organized statewide approach to addressing elder sexual abuse. The overall goal of the project is to insure an appropriate response to sexual abuse that will not further traumatize the elder victim, but aid in his or her healing from the profound emotional and physical injury resulting from the sexual violence.

Initially, the project focused on the implementation of the Addressing Elder Sexual Abuse: Developing a Community Response curriculum, an interdisciplinary training curriculum to better equip sexual assault advocates and area agency on aging protective service workers to coordinate in their efforts to combat elder sexual abuse. This multimedia curriculum aimed to facilitate collaboration among professionals. This resource is available to you online: www.aging.state.pa.us under publications.

The project also seeks to provide sexual violence advocates with a tool in the form of a technical assistance manual to most effectively serve elder clients. **The goal of this technical assistance manual is to allow sexual violence advocates/counselors to become adept in dealing with elder clients as needed.** Advocates can peruse this guide to learn the basics of effectively working with elder clients, or utilize it in a crisis situation. For example, an advocate could quickly turn to the medial advocacy section when called to the hospital for an elder victim. Many sections end with on-line resources on each subject, so advocates can learn more if they so desire. The PCAR library also houses a variety of books, articles, curriculum, and videos on elder sexual assault and other topics reviewed in this manual. The goal of creating this technical service manual is to make your job easier.



Understanding Aging

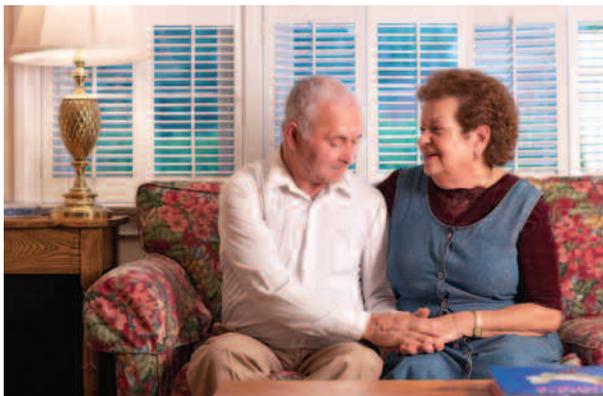
Older Americans, defined age 60 and above in Pennsylvania, are a large and growing segment of our population.

- Pennsylvania is second nationally in the number of 65 and older; Florida is the state with the largest number of seniors.
- One in five people in PA are 60 and older.
- By 2020, one in four people in PA will be 60 or older representing 25 percent of the Pennsylvania's population (U.S. Bureau of the Census, Census 2000 and PA Population Projections, Pennsylvania State Data Center, 1998).
- One in five older Pennsylvanians lives in or near poverty, and more than 200,000 are identified as members of a minority group. (www.aging.state.pa.us)
- Over the next 50 years, the population age 85 and older is expected to grow faster than any other age group.
- The female to male ratio is 100 to 70, and increases as age increases (Administration on Aging. "A Profile on Older Americans: 2003." www.aoa.dhhs.gov).

10 Concepts on Aging

The best time to learn how to grow old with dignity and grace is during the younger years, and the best place is everyday life. Understanding all aspects of the aging process enables us to understand more clearly those who are aged. The following general statements offer a foundation for studying the aging process.

- **Aging is Universal.** It is common to every population and is not just a modern-day phenomenon in western civilization.
- **Aging is Normal.** 'Growing up' is spoken of with respect; 'growing old' with fear. This fear develops from the stereotyped picture of aging as a loss of faculties, beauty, energy, and memory.
- **Aging is Variable.** Each individual ages in a unique way. The state of later life develops from former personal life patterns.



Nursing Home or Facility

A facility that provides nursing care and related medical or other personal health services 24 hours a day and 7 days a week to individuals who require full-time care or supervision but do not need more intensive hospital-based care.

Ombudsman

A person who advocates for and protects the rights of older persons receiving long-term care services. An ombudsman is available at Area Agencies on Aging to investigate complaints made by or on behalf of older persons in long term care facilities, such as nursing facilities, personal care homes, and domiciliary care homes.

Personal Care Homes

Any premises where four or more un-related adults who do not require nursing care reside and receive food, shelter and personal care, financial management or supervision for periods exceeding 24 continuous hours.

www.aging.state.pa.us to Long Term Care link under Quick Links to Definitions link

Living Situations of Elderly Victims and the Process of Recovery

Independent Living. Seniors living independently include those living with their family and/or partners as well as those living alone. If the senior who is raped is alert, verbal and with minimal memory deficits, the sexual violence advocates generally follow usual protocol for support services as they do for adult victims in general. That is, meet with the senior, assess social network support, provide crisis counseling, and work with the prosecutor's office if the case is scheduled for trial.

Assisted Living. An elder living in assisted living generally implies there is a protected environment that has safety features in place. That is, staff checks on them over 24-hour shifts, and meals and cleaning services are often provided.

When an elder is sexually assaulted in a perceived safe environment, such as assisted living and/or institution, it causes additional trauma because staff has been trusted and the sense of safety and security has been breached. Very often, the family feels guilty for not keeping the elder at home. Intervention for the elder needs to focus on verbal and nonverbal signs of stress, behavioral disorganization, aggression, functional ability, and health status. The traumatized elder needs careful observation and a good description of pre-assault behavior from family and staff members for a base line to assess changes.

A 68-year-old woman was raped and robbed of \$80 by an intruder who kicked down her door. The offender managed to get into the apartment building lobby and past a locked front door. The woman had just returned home and left the apartment door ajar. The man walked up to the woman's apartment and asked if he could use her phone. The woman answered that he could not and shut the door, but he kicked open the door, pulled out a knife, and ordered her not to scream. An hour later, the woman's husband returned home, found his wife in shock, and called 911. The husband's support and the encouragement provided by the sexual assault counselor/advocate and prosecutor enabled the victim to testify in court and helped to win a conviction.

Living Situations and Advocacy

Many elder clients a sexual violence agency may see reside in a care institution or receive health care services from a number of community resources. This section should provide an overview of the variety of services available and how to best advocate for the victim within institutions. Understanding the culture of care could be an essential part of providing appropriate advocacy for the victim.

Care Information: Definitions

Adult Day Services

Services, generally provided on a part-time basis at community-based Adult Day Centers, that are designed to meet the needs of functionally impaired adults age 18 or older. The services include but are not limited to personal care, assistance with eating or using the toilet, assistance with taking medications, therapies and social activities. Adult Day Centers offer a protective supervised setting for these services and generally operate during normal business hours, five days a week. Some Centers offer services in the evenings and on weekends.

Attendant Care (Personal Assistance Services)

A wide range of supportive services or activities provided part-time or full-time to adults who have physical disabilities, in a way that recognizes and enhances the highest level of independence possible for each individual served. Essentially, personal assistance services are in-home personal services, flexibly adapted to the individual's needs and capabilities. The services of the attendant focus on personal services needs and may also include other in-home services.

Continuing Care Retirement Communities

Communities that offer a range of housing, support, and health care services so older people do not have to move when their needs change. Many offer independent and assisted living units as well as nursing home care, all at one campus.

Domiciliary Care Homes

Private residences with a family-like atmosphere that provide services for up to 13 persons; individuals and/or couples age 19 years or older. Domiciliary Care Homes must be certified by the Department of Aging and must meet state and federal fire, safety, health, sanitary, and program standards. Financial assistance with monthly charges may be available to persons with low to moderate income.

Home Health Care

Nursing and other health care services provided in your home as ordered or prescribed by your physician. These services are provided by registered nurses and/or licensed health aides and include but are not limited to skilled nursing services, therapies, personal care and daily living services, changing and reinforcing simple wound dressings, monitoring temperature, blood pressure and weight, performing simple measurements and tests, assisting with ambulation and medical equipment use and other auxiliary health services.

Hospice Care

Medical, psychological, and spiritual support to the terminally ill, as well as support for the patient's family, by a core interdisciplinary team of professionals and volunteers. The care is primarily based in the home, enabling families to remain together in peace, comfort, and dignity.

- Dying is Normal and Inevitable. It is difficult for many to accept the idea that while a full, satisfying life is being lived, death can be anticipated as a meaningful closure of life.
- Aging and Illness are Not Necessarily Coincidental. The stereotype image again lingers, but individuals should prepare for healthy old age through improved living habits in early and middle years.
- Older People Really Represent Three Generations. The group known as the "aged" covers the years 65-112, representing two, and often three, generations and may include parents, grandparents, and great-grandparents. No other age group includes such diversity.
- Older People Can and Do Learn. Capacity to learn new things and re-learn the old is not necessarily diminished by old age. Learning patterns may change from youth and the speed of learning may slow, but learning ability appears to be culturally determined, not restricted by years.
- Older People Can and Do Change. As one grows older, many adjustments become necessary. Mates die, housing situations change, new activities are developed, and new friendships established.
- Older People Want to Remain Self-directed. Where dependency on others for decision making exists among older people, it has often been learned as a direct result of loss of a sense of purpose and self-respect. To prevent this loss when older adults undergo life changes, their self-direction and sense of control should be maintained as much as possible, even if they become dependent in some ways.
- Older People are Vital Human Beings. Although physical disability is often associated with mental inadequacy, it should be recognized that the need for physical help in crossing the street does not mean that the person does not know where he is going.

Note: reprinted with permission.

Elder Abuse Awareness Kit. National Association of Adult Protective Service Administrators for the National Center on Elder Abuse. March 2001. www.elderabusecenter.org

Elder Sexual Assault

Sexual offenders are attracted to vulnerability. Perpetrators seek out potential victims who they perceive as easy to overpower and manipulate. They look for those who would be unlikely to report the assault and who would not be deemed credible if the assault were reported.

Older adults are especially vulnerable to sexual violence, and elder sexual assault is one of Pennsylvania's most hidden crimes. Unfortunately, while elder sexual assault victims may require more assistance and specialized help, they often receive less services and intervention than younger victims for a number of reasons.

Certain factors associated with the aging process put the elder population at heightened risk. In some cases, people of advanced age need others to provide basic necessities and assistance with daily functions. These circumstances increase one's risk of sexual assault; elders are often victimized by those assisting them or those closest to them. Reduced cognitive or emotional functioning may also render older people more susceptible to sexual assault. Even for well elders, the social stigma of old age make them an easier target for perpetration and more likely to remain silent if victimized.

A working definition of elder sexual abuse: Any time a person 60 and over is forced, tricked, coerced, or manipulated into unwanted sexual contact. It also includes sexual contact with elders who are unable to grant informed consent or sexual contact between service providers and their elderly clients.

www.preventelderabuse.org/nexus/hrklawsnik.html

For victim service providers, there are other key factors that should be recognized when exploring the hidden nature of this crime.

- Few resources are available for educating seniors and others about the prevention of sexual abuse.
- Anecdotal and research data are scarce on the efficacy of treatment programs in the area of elder sexual abuse.
- There is a history of discrimination against the elderly, as well as misperceptions and stereotypes against older adults that has put elders at an increased risk for sexual assault.
- Barriers to effective health care interventions include delayed reporting of the sexual abuse that results in failure to obtain a timely forensic evidentiary examination and treatment for injuries and infection.
- Little information is available on the motivation of offenders who sexually assault the elderly to provide direction for early detection to reduce offending behavior.

(Dr. Ann Burgess for PCAR, 2004)

Employees: An employee is defined as any applicant or new employee who has been hired since July 1, 1998. Includes contract employees with direct contact with residents or unsupervised access to their personal living quarters. Also includes persons employed or contracted to provide care to a care-dependent individual for monetary consideration in the individual's residence.

Facility: The types of facilities covered by the Act are as follows: domiciliary care homes, home health agencies, long-term care nursing facilities, adult day care facilities, and personal care homes. The Act also includes any private or public organization which provides care to a care-dependent person in their residence.

Process: An applicant/new hire who has been a resident of the state for the last two years uninterrupted needs to obtain a "Request for Criminal History Background Check" from the nearest PA State Police barracks. The applicant/new hire will complete the application and forward it with a money order or cashier's check for \$10 made payable to "Commonwealth of PA" to the State Police for processing. The Act does allow for the provisional hire of an employee for 30 days if the employee can provide proof they have applied for the background check. If there is no criminal history record, the PSP will forward a letter stating the same. If there is a criminal record, the PSP will forward a copy of the rap sheet to the requester.

If the applicant has not been a PA resident for the two years before application, they will need to have a PSP criminal history background check completed and an FBI Background Check. The applicant will obtain an FBI fingerprint card either from their prospective employer or by contacting PDA. After obtaining the fingerprint card the applicant will go to police to be fingerprinted. The completed card (fingerprints and requested information) will be forwarded to PDA along with a money order, cashier's check, or certified check for \$24 made payable to "FBI".

The fingerprints will be forwarded to the FBI for processing by PDA. The normal processing time is between 60 and 90 days. The Act does allow for the provisional hire of an employee who requires an FBI check for 90 days, if the employee can provide proof they have applied for the background check. When the application has been processed by the FBI, the results will be returned to PDA. When there is no criminal history record information recorded, a clearance letter will be sent to the applicant/employer. If there is an open disposition for a prohibitive offense, a letter will be sent to the applicant requesting the disposition of the case for determination of eligibility for employment. If there is a conviction for one of the prohibitive offenses, a prohibitive hire letter will be forwarded to the applicant/employer.

Link to Pennsylvania Law on Protective Services for Older Adults

www.pacode.com/secure/data/006/chapter15/chap15toc.html

- 3) Intermediate care facilities for individuals with mental retardation, including State and non-State operated facilities and homes; and,
- 4) State mental hospitals

Every report of abuse received by the Area Agency on Aging must be investigated to determine if the reported victim needs help to protect himself or herself from abuse, neglect, exploitation or abandonment. Each report must be classified as emergency, priority or non-priority. Emergency reports are investigated immediately; non-priority reports are investigated within 72 hours.



Once the incident has been identified as protective and it has been determined that service provision is necessary the Area Agency on Aging in most cases must have the older adult's consent to provide protective services. Permission is not required if the services have been ordered by a court, requested by the older adult's court appointed guardian, or provided as part of an involuntary, emergency intervention court order because of imminent risk of death or serious physical injury.

All services offered to victims of abuse, neglect, exploitation or abandonment must be based on a comprehensive assessment of the victim's needs and described in a written service plan presented to the victim for his/her approval.

Finally, in the provision of protective services certain rights must be guaranteed. Those rights are as follows:

- Victims have the right to be told that someone has reported that they might be the victim of abuse and need protective services.
- Victims can refuse to accept services.
- Victims have the right to legal counsel when the Area Agency on Aging attempts to obtain an emergency, involuntary intervention court order.
- Victims have the right to a guarantee that all information concerning their case will be maintained confidential.
- Alleged abusers have the right to be notified after substantiation of a report and given an opportunity to challenge the findings of the investigation. www.aging.state.pa.us

Act 169 of 1996

Purpose: Requires criminal history background checks for employees of Nursing Homes, Personal Care Home Domiciliary Care, Home Health and Adult Day Care. Employees with convictions for prohibitive offenses are precluded from working in these facilities.

Prohibitive Offenses: Criminal Homicide, Aggravated Assault, Kidnapping, Unlawful Restraint, Rape, Statutory Sexual Assault, Involuntary Deviate Sexual Intercourse, Sexual Assault, Aggravated Indecent Assault, Indecent Assault, Arson and Related Offenses, Burglary, Robbery, Theft (Felony or 2 Misdemeanors), Forgery, Securing Execution of Documents by Deception, Incest, Concealing Death of a Child, Felony Drug Offense, Child Endangerment, Dealing in Infant Children, Intimidation of a Witness, Retaliation Against a Witness, Prostitution (Felony Offense), Obscene or Other Sexual Materials and Corruption of Minors.

Why Elder Sexual Abuse Goes Unrecognized

While elder sexual assault is beginning to gain recognition in Pennsylvania, it is still only an emerging issue. The stories of elders sexual abused within nursing homes are filtering into Pennsylvania's newspapers, and are met with shock and disbelief. This is related to the misconception in the larger society that sexual violence is related to sexual attraction as well as the societal view of elders as asexual or undesirable.

What we know about Elder Sexual Assault

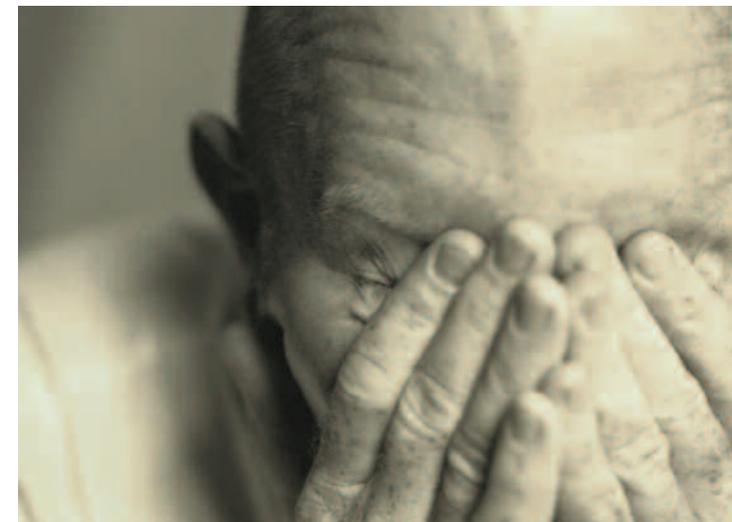
While elder sexual abuse research is still in its infancy, studies have identified characteristics that can help define the problem.

- Perpetrators are likely to be paid or unpaid male caregivers.
- Older victims are most often females over age 70, who are totally dependent or functioning at a poor level.
- Older victims suffer more genital trauma from sexual assault than younger victims.
- Older victims are less likely to report sexual abuse than younger victims.

Resources:

For a complete annotated bibliography on elder sexual abuse, go to the National Center on Elder Abuse's Clearinghouse on Abuse and Neglect of the Elderly (CANE). The list is under the CANE Bibliography series: www.elderabusecenter.org

Sexual Abuse of the Elderly, Forensic Nurse magazine, by Barbara Katayama, RN, BSN, LNC www.forensicnursemag.com and search for the author's name.



Generational Differences

Language

An elder may use different terms than those which you are familiar, especially when referring to private parts of her/his body. When beginning work with an elder, be cognizant of the terms you use. Do not use vocabulary that can be labeled as part of a particular generation, but instead use “timeless,” simple words anyone could understand and relate to.

When talking about private parts, allow the elder to choose the terminology she or he is most comfortable with and then use the same terms. If this is not possible, choose to refer to those areas as generally as possible. Anatomically correct terms are not the best to use when working with an elder—older generations, especially women, were shamed to use these words because one did not speak of such areas. Many elders still use terminology like “down there” or a childish nickname for their genitalia.

Perceptions of Rape

The definition or a person’s perception of what rape and/or sexual violence is and how/why it is perpetrated is a reflection of what they have been socialized to believe as well as personal experience. Views about sexual violence have changed dramatically in the last three decades due to the anti-sexual violence movement and other factors. Advocates have worked hard to create a society that blames the victim less and acknowledges the reality of sexual violence as well as the fact that rapists aren’t always strangers. This is not always the case, but progress is apparent.

Elders may still hold generational beliefs, such as:

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

Internalization of Rape Myths

These views influence a skewed view of rape and sexual abuse: many elders still hold onto the myths that only strangers rape women, only women get raped and that good

An elder Pennsylvania woman was raped by a stranger. He forced her to perform oral sex on him, something the woman had never done before. The woman told the police she had been raped, and was taken to the hospital for a sexual assault forensic exam. The woman was so ashamed of performing oral sex that she told no one the rape had been oral. As can be expected, the exam showed no signs of vaginal rape, and the police became suspicious of the woman’s claim. Eventually, the woman’s rape case was dropped. Only in counseling, months later, after questioning about the rape and how it happened, did the woman break down and disclose that she had been raped orally. She was so ashamed of having participated in oral sex that she could not admit that the assault had been oral, and police and others assumed she would disclose that information not recognizing the stigma and shame attached to oral sex by the elder generation.

If the employee or administrator believes the abuse involves sexual abuse, serious physical injury, serious bodily injury or suspicious death they are also required to make an immediate oral report to law enforcement and to PDA in addition to the oral and written report to the AAA. Within 48 hours of making the oral report the employee or administrator shall follow-up with a written report to law enforcement officials.

Within 48 hours of receiving a report of sexual abuse, serious physical injury, serious bodily injury, or suspicious death, the local AAA shall forward a written report to PDA.

When the local AAA receives a report concerning suspicious death, the AAA will make an oral report to the coroner and follow-up with a written report within 24 hours.

Failure to comply with Act 13 can result in administrative and criminal penalties. The licensing agency for the facility will have jurisdiction to determine any administrative violation and may issue a civil penalty up to \$2,500. Additional criminal fines and penalties of up to one year imprisonment are included for criminal violation of the Act.

About Older Adult Protective Services

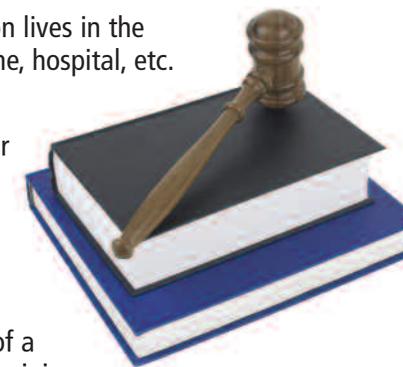
In the Protective Services program there are two types of reporting – voluntary and mandatory.

Voluntary Reporting

- Any person who believes that an older adult is being abused, neglected, exploited or abandoned may file a report 24 hours a day with any Area Agency on Aging or call the statewide elder abuse hotline at 1-800-490-8505.
- Abuse reports can be made on behalf of an older adult whether the person lives in the community or in a care facility such as a nursing home, personal care home, hospital, etc.
- Reporters may remain anonymous.
- Reporters have legal protection from retaliation, discrimination and civil or criminal prosecution.

Mandatory Reporting

- Employees and administrators of nursing homes, personal care homes, domiciliary care homes, adult day care centers and home health care are mandated by Act 13 of 1997 to immediately report any suspected abuse of a recipient of care to the Area Agency on Aging. If the abuse involves serious injury, sexual abuse or suspicious death, reporters **must** also call police and the Pennsylvania Department of Aging at (717) 783-6207. In addition, the reporter may also call the Pennsylvania Department of Health Nursing Home Complaint Line at 1-800-254-5164.
- Failure to report as required by Act 13-1997 can result in administrative or criminal penalties.
- The Older Adults Protective Services Act (OAPSA), mandatory abuse reporting requirements have been amended. Effective February 9, 2003, facilities that provide services to individuals with mental retardation in residences licensed by the Pennsylvania Department of Public Welfare (DPW) or that are funded through a County Mental Retardation (MR) program shall not be required to report abuse if the recipient is under the age of 60 years. Specifically this includes:
 - 1) Community residential rehabilitation services;
 - 2) Community homes and family living homes for individuals with mental retardation;



Aging Services and Laws in Pennsylvania Pennsylvania Department on Aging

Area Agencies on Aging

The Area Agencies on Aging (AAA) are the local representatives of the Pennsylvania Department of Aging. They implement the various programs for older Pennsylvanians. There are 52 such offices, serving all 67 counties. They are staffed with caseworkers skilled in such areas as geriatrics, social work and community resources. They can assist you with questions regarding nursing facilities, community services in nursing facility placement, and a wide range of other community services tailored to your specific needs.

Pennsylvania's Aging Laws

Older Adult Protective Services Act

Act 79 of 1987 or the Older Adult Protective Services Act (OAPSA) was created to protect elder Pennsylvanians who may lack the capacity to protect themselves and who are at imminent risk of abandonment, abuse, exploitation or neglect. The act gave the Pennsylvania Department of Aging and the Area Agencies on Aging (AAA) the legal base to provide protective services. It assigned the AAAs to provide protective services as deemed necessary through investigation to protect PA elders.

Act 13, an amendment to the Older Adult Protective Services Act, requires administrators and employees of nursing homes, personal care homes, domiciliary care homes, adult day care centers, and home health care providers to report incidents of suspected abuse of any person who is receiving care from the agency, regardless of age.

Purpose: Requires employee or an administrator of a facility who has reasonable cause to believe that a recipient is a victim of abuse to immediately report the abuse. The effective date was December 10, 1997.

Abuse: The occurrence of one or more of the following acts: (1) The infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish; (2) The willful deprivation by a caretaker of goods or services which are necessary to maintain physical or mental health; (3) Sexual harassment; and/or (4) Sexual abuse which is intentionally, knowingly or recklessly causing or attempting to cause rape, involuntary deviate sexual intercourse, sexual assault, statutory sexual assault, aggravated indecent assault, indecent assault or incest.

Facility: The type of facilities impacted by the Act are: long-term care nursing facility, personal care home, domiciliary care home, home health agency, and an adult daily living center.

Recipient: An individual who receives care, services, or treatment in or from a facility.

Serious Bodily Injury: An injury which creates a substantial risk of death or which causes serious permanent disfigurement or protracted loss or impairment of the function of a body member or organ.

Serious Physical Injury: An injury that causes a person severe pain or significantly impairs a person's physical functioning, either permanently or temporarily.

Process: When an employee or administrator has reasonable cause to believe that a recipient is a victim of abuse they shall immediately make an oral report to the local AAA. Within 48 hours of making the oral report the employee or administrator shall make a written report to the AAA.

girls do not get raped. If an elder believes these myths, imagine the trauma if she or he becomes a victim of sexual abuse. The amount of self-blame could be monumental. For example, a bedridden widower in a nursing home was raped by a nurse aide. She was devastated by the incident because she felt she had cheated on her husband and somehow seduced the aide.

If you are working with an elder client, remember that she or he was raised and lived an adult life in a different era where women were much more oppressed within society, institutions and public policy. For example, rape was legal within marriage until 1984 when the Pennsylvania spousal rape law was passed. When working with a 76 year old woman, keep in mind that she lived in a world where her husband could legally rape her until she was 55.

It is important to note that elder male victims may experience the trauma of sexual violence three-fold. While women were oppressed, men were forced into the position of power and control. The loss of power due to sexual violence over being "manly" and maintaining control in all situations may be a defeat some men are unable to handle.

Childhood Sexual Abuse

An estimated 3.5 million women sixty years of age and older are survivors of childhood sexual abuse. (Farris, M. and Gibson, JW. 1992. The Older Woman Abused as a Child: Untold Stories and Unanswered Questions.)

As mentioned earlier, elders grew up with different generational beliefs about rape and abuse. Child sexual abuse was largely not recognized as a problem, and in many cases, children who disclosed molestation were not believed. In other cases, children were told to ignore and move past the assault. In either case, childhood victims of sexual abuse that are revictimized as elders may be less likely to disclose and may tend to internalize reactions to the recent abuse. In turn, these reactions to abuse can manifest as physical problems, irregular behavior, post-traumatic stress disorder, substance abuse problems, and depression, as well as a multitude of other life long conditions.

On the other hand, due again to the generational factors discussed above, there is a greater likelihood of an elder repressing a prior assault, only to have the affects resurface in later years. Any number of incidents can trigger a reaction to prior sexual abuse—and this list can go on and on because triggers are personal to individuals and the assault. As with other clients, an elder may ask for services to address sexual victimization that occurred 70 years ago.

Conditions such as dementia can make an individual more sensitive to triggers and/or bring up recessed memories. In several cases, elders with dementia have disclosed their assault as current. The stage of dementia effects how competent an individual may be, so if asked to work with a demented client, find out as much as possible about the state of the individual and stage of sickness. Refer to counseling section for tips on working with demented or cognitively impaired elders.

As a teenager, a woman was raped on her way home from school. She didn't tell anyone about the rape, until discovering she was pregnant. When she told her mother how she had become pregnant, she was forced to reveal the name of her rapist. Her mother slapped her upon finding out the father was not the girl's betrothed, and forced her to marry her rapist. The women lived as the wife of her rapist until his death as a middle-aged man. It was sixty years before she told anyone else about her assault.

Providing Effective Advocacy

Elder victims need the same services and crisis interventions as younger victims: nonjudgmental emotional support, medical care, and legal information when appropriate and desired. The [sexual violence advocate](#) asks: "What can I do? What can I say? How do I help?" There are general concepts of being helpful to elders, having therapeutic attitudes, human qualities of the advocate as well as specific therapeutic tasks.

[Attitudes and human qualities of the advocate.](#) Self-assessment requires examining one's attitudes and style related to working with seniors. It involves being aware of the interpersonal assets and talents the advocate brings to the situation. It further involves knowing what qualities and skills must be further developed within the advocate to provide the most helpful interchange with the elder. The self-assessment process is the constant examination of feelings, attitudes, and actions. Ideally, each new situation should be started with an open mind. But how often is that the case? For example, some bring warm, positive experiences with aging relatives to an encounter with an elder while others bring attitudes that sexual abuse of an elder could not occur. The advocate needs to be prepared to examine and understand whatever feelings and attitudes are activated in cases of elder sexual abuse.

[Respect](#) for the elder is the building block for a helpful relationship. The term respect is used in the sense of paying attention to, observing carefully and appreciating the worth and dignity of another person. The advocate communicates respect by taking the elder seriously, by being honest, by listening well, and by regarding the elder as a person instead of an object. Failing to do the above may give false reassurance or infantilize the elder. Being able to communicate respect is a powerful therapeutic tool.

[Optimism is important.](#) The advocate must believe that every victim can be helped. This may be hard to accept with the victim suffers from a dementia, cannot speak and is curled into a fetal position. Even in the most desperate of situations, it is important to hold to the basic assumption that every human interaction has the potential for being therapeutic. Not every elder will recover, but some suffering can be relieved. Elders can be helped if they have hope: they can only sustain a feeling of hope if the advocate communicates that feeling to them.

[There are positive aspects to all people.](#) Abused elders whom advocates like and find interesting will usually respond to interventions more rapidly than seniors who are not liked. If this is true, advocates may face the task of learning to like or at least finding something positive about a withdrawn, physically, and/or mentally handicapped, uncooperative elder. How can this be done? First, advocates must acknowledge any negative feelings (self-assessment). The task is to determine what about the elder is disturbing: withdrawal or dementia or perhaps personal grooming? Then the task is to determine what could hinder service provision: possibly feelings of helplessness or anxiety about failing. At this point, it is helpful to discuss one's feelings with a supervisor or other advocates. If the elder is pushing people away, the advocate can find good reason in the

Resources:

Administration on Aging Alzheimer's Resource Room
www.aoa.gov/alz/index.asp

Depression

As mentioned above, depression in older adults can be mistaken and misdiagnosed for dementia. Almost 20 percent of adults 65 and older display severe depressive symptoms. (Health and Retirement Study, National Institute on Aging, 2000. hrsonline.isr.umich.edu/index.html) Being aware of the high rate of depression in elders will allow the advocate to best serve the client.

Some people have the mistaken idea that it is normal for the elderly to feel depressed. On the contrary, most older people feel satisfied with their lives. Sometimes, though, when depression develops, it may be dismissed as a normal part of aging. Depression in the elderly, undiagnosed and untreated, causes needless suffering for the family and for the individual who could otherwise live a fruitful life. When he or she does go to the doctor, the symptoms described are usually physical, for the older person is often reluctant to discuss feelings of hopelessness, sadness, loss of interest in normally pleasurable activities, or extremely prolonged grief after a loss. www.nimh.nih.gov/publicat/depression.cfm



Physical Disabilities

Understanding Assistive Technologies

Overview of Assistive Technology for Persons with Disabilities, prepared by the Disabilities Law Project

How To Pay for Assistive Technology, prepared by the Disabilities Law Project

Communication Devices for Nursing Facility Residents, prepared by the Disabilities Law Project
www.dlp-pa.org under Publications

Making your Center Accessible

Accessible Parking for People with Disabilities, prepared by the Disabilities Law Project
www.dlp-pa.org under Publications

Understanding Disabilities

Cognitive Disabilities

Alzheimer's

Alzheimer's disease (AD) is a progressive brain disorder that gradually destroys a person's memory and ability to learn, reason, make judgments, communicate and carry out daily activities. As Alzheimer's progresses, individuals may also experience changes in personality and behavior, such as anxiety, suspiciousness or agitation, as well as delusions or hallucinations.

Scientists think that up to four million Americans suffer from AD. The disease usually begins after age 60, and risk goes up with age. While younger people also may get AD, it is much less common. About 3 percent of men and women ages 65 to 74 have AD, and nearly half of those age 85 and older may have the disease. It is important to note, however, that AD is not a normal part of aging. "Alzheimer's Disease Education and Referral Center, a service of the National Institute on Aging." www.alzheimers.org

Dementia

Alzheimer's is the most common form of dementia, a group of conditions that all gradually destroy brain cells and lead to progressive decline in mental function. Vascular dementia, another common form, results from reduced blood flow to the brain's nerve cells. In some cases, Alzheimer's disease and vascular dementia can occur together in a condition called "mixed dementia." Other causes of dementia include frontotemporal dementia, dementia with Lewy bodies, Creutzfeldt-Jakob disease and Parkinson's disease.

Sometimes older people have emotional problems that can be mistaken for dementia. Feeling sad, lonely, worried, or bored may be more common for older people facing retirement or coping with the death of a spouse, relative, or friend. Adapting to these changes leaves some people feeling confused or forgetful. Emotional problems can be eased by supportive friends and family, or by professional help from a doctor or counselor.

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Counseling a Victim with Cognitive Disabilities

There is very little research on this topic, but there are important facts to keep in mind. First, elders with a cognitive disability are in varying stages of competency, as illustrated above. Working with a victim's family or doctor, if feasible and best for the victim, to determine the stage of ability to participate in counseling—and testing the waters with the elder yourself to determine the level of comprehension and response—can be a best approach. For cognitively disabled client in later stages, music therapy has proven to be effective. Advocates visiting elder victims in an institution or working with elders at the center can use the technique of music therapy. It requires having a tape recorder and tape of music selected by the elder. The goal of the therapy is to help the victim learn to reduce the anxiety experienced during the assault and in the activation of rape trauma aftermath symptoms. See the section on Suggested Approaches to Elder Victims in Nursing Homes under **Living Situations & Advocacy**.

(Dr. Ann Burgess for PCAR, 2004)

details of the sexual assault. If the elder is withdrawn, the behavior is the best she or he can do at that particular point in time. If the advocate enters into the world of the senior, the behavior will have meaning. At the same time the advocate will find a real suffering human being, struggling in the best way she or he knows to survive. Using this approach, the advocate will likely find something about the elder to respect.

Sensitivity. Being sensitive is becoming acutely aware of the subtle changes in thought, mood or behavior in another person. It is a feeling or hunch that something is not right. It is listening, looking and feeling intently. In a sense, it is having one's own radar. For example, the elder might appear more reserved and thoughtful than previously. The advocate might say, "Hello" and pause for the elder to respond. If the elder does not respond, the advocate might say, "I have a feeling there is something on your mind." Using the human quality of sensitivity, the advocate is able to communicate to the elder an awareness that something is on his or her mind and an interest in listening to those thoughts.

Caring. Initially, one should start by just listening and trying to understand the human process within the elder rather than trying to focus on specific interview techniques. Interest and caring about an elder are not technical skills; they are the basic arts of psychic healing.

Advocates may not need to tell the elder they care. They show concern by listening and trying to understand the anguish or loneliness in the elder's heart. When the advocate and elder are comfortable enough to not worry about interview technique, posture, facial expression, and speech, the natural concerns for elders will begin to show.

Patience and persistence. The importance of patience that is required in the healing process of the mind is frequently underestimated with victims of all ages. Working with elders where there are often additional health problems and a decline in thinking and memory requires patience. This quality coupled with the physical presence of the advocate often provides the first affirmative therapeutic results. There may be weeks (and months) when the advocate does not feel any progress is being made. However, the physical presence at a regularly scheduled time can and often does set the stage for therapeutic success. It is important to remember that therapeutic process must not be rushed and miracles should not be expected; the advocate must persist. The elder victim in a nursing home may have been neglected for a length of time prior to the sexual assault. Patience and persistence usually win out in the end as those qualities demonstrate concern, interest, and caring.

(Dr. Ann Burgess for PCAR, 2004)

Diversity and Elder Clients

Cultures and/or ethnicities may have varying beliefs about growing old and the role of the elder in society. Being aware of these differences can be essential to building rapport with a client. Since cultural learning is a lifelong process, entering into each interaction with sensitivity to potential issues is advisable. Letting the client know initially that the intent is not to offend his or her beliefs by any of your statements or actions, but that the client should share if any unintentional offense should occur during interaction. Asking the client about his or her culture could be a good place to begin. Most people can respect that individuals do not know everything about other cultural norms, and respect the desire to learn more. Recognizing and addressing potential cultural factors is a respectful practice.

Resources:

www.ethnicelderscare.net/index.htm

Site for caregivers of ethnic elders with Alzheimer's or a related disease. Excellent "Resources" page and helpful links.

www.aoa.gov/prof/adddiv/cultural/CC-guidebook.pdf

Achieving Cultural Competence: A Guidebook for Providers of Services to Older Americans and Their Families, January 2001, Administration on Aging

www.elderabusecenter.org under Clearinghouse on Abuse and Neglect of the Elderly bibliography on cultural issues in elder abuse.

Sexuality

Gay/Lesbian/Bisexual/Transgender/Intersex individuals remain a marginalized group in our culture despite the progression of policies like Vermont's civil union law and Massachusetts' recent marriage law allowing same sex partnerships. The reality exists that gays, lesbians, bisexuals, transgender and intersex individuals age as well, and many of these individuals aged in a period where "coming out" was simply unthinkable. Keeping an open mind about the sexuality of all clients, including elders, can be important in establishing an effective counseling relationship.

Resources:

www.survivorproject.org/elderabuse.html

Lesbian, Gay Male, Bisexual and Transgendered Elders: Elder Abuse and Neglect Issues By Loree Cook-Daniels, Transgender Aging Network

http://www.forge-forward.org/handouts/LGBT_Elders.pdf

LGBT Elders: Domestic Violence / Sexual Assault Resource Sheet



Resources:

Power of Attorney, prepared by the Disabilities Law Project

www.dlp-pa.org/pubs/factsheets/POA_2003.pdf

Guardianship in Pennsylvania, prepared by the Disabilities Law Project

www.dlp-pa.org/pubs/manuals/Guardianship_2003.pdf

Police and Court Advocacy

PCAR has created a brochure titled "Preparing and Prosecuting Elder Sexual Assault Cases." The brochure is for advocates, police, victim witness professionals and district attorneys. Civil attorneys may also find the booklet helpful with properly advocating and serving their elder clients. The booklet reviews effective techniques for interviewing elders as well as practical ways to work with an elder client within these systems. Many of the interviewing tips could also be helpful to sexual violence advocates. This resource is available to you online at www.aging.state.pa.us under Publications.

PCAR will also be alerting the Florida Council Against Sexual Violence's Elder Sexual Abuse Law Enforcement Training Curriculum to reflect Pennsylvania laws. The resource can be found online at the Council's website www.fcasv.org



Understanding Guardianship in Pennsylvania

- Guardianship of adults must be assigned by a court; parents of designees have guardianship over minors.
- Everyone over 18 is their own guardian unless guardianship is given by a court.
- Three Types of Guardianship Orders
- Guardian should be able to produce a court record of guardianship procedures.
 - Person (various powers over healthcare, living arrangements)
 - Property (various over finances, income)
 - Plenary (guardianship of both)
 - As always, the exception is guardian ad litem, guardianship over specific, necessary roles (examples: general care, medical decisions over \$100, etc.) Can be granted for a limited period of time.
- Only guardians of person can make medical decisions, other types have no power in this area.

Understanding Power of Attorney

- A signed contract between two parties who are capable of granting legal consent
- Allows only specific powers, e.g. healthcare/medical, financial, etc.
- Power of Attorney is revocable if both parties have capacity (a challenge to guardianship requires court reversal)

What This Means: the Forensic Rape Exam and Incapacitated Individuals

- If there is an emergency situation in a medical facility, patient consent is not needed.
- Hospitals are more likely to provide treatment to avoid litigation. If hospital staff is refusing treatment, the advocate can request to speak to the hospital's lawyer.
- If a person is claiming Power of Attorney or Guardianship and she or he is not in favor of giving the victim the forensic rape exam, the advocate can ask to see proof of Power of Attorney or Guardianship.



Factors influencing how elders will respond to sexual abuse

While each victim experiences and recovers from sexual violence differently, these factors may help advocates understand how the episode can be unique for elders.

- **Personality and Life History.** How well does the individual deal with the challenges of old age? Is she or he aging well? Is the individual optimistic, willing to adapt, have a healthy self esteem, a sense of personal power and responsibility? A person who displays those qualities is likely to have responded positively to other challenges in life.
- **Emotional state at the time of the crime.** As people age, they accumulate various types of losses—such as family, job, status due to retirement, strength, and ability. As each loss accumulates, what remains becomes even more important. If an elder was dealing with something like the death of a spouse or a debilitating disease, sexual abuse could seem like an overwhelming defeat.
- **Intensity and duration of the criminal event.** As for any victim, the severity of the assault will influence the victim. Elders may respond with even greater shock due to naivety to violence and a heightened state of a loss of control doubled with the natural losses accompanying old age.
- **Perception of recovery potential.** Injuries from sexual violence are more severe because elders bruise and tear more easily and take longer to recover. In some cases, elders may experience injuries that will never fully heal due to sexual abuse. When the impact of crime is painful and permanent, victims may find the emotional road to recovery overwhelming.

Potential Problems When Working with Older Victims

While none of these potential problems may arise, it is best for advocates to be aware of what could occur so they are prepared.

- **The age of a younger advocate may be a block for an elder victim.** Elders are very aware of age difference, and tend to label themselves as “old.” As discussed above, generational differences make sex and sexual abuse difficult topics of discussion and some elders may refuse to discuss such matters with a person the age of their grandchild. While consistent work with a younger advocate could prove effective after rapport is established, assigning an older advocate to an elder victim may avoid potential barriers.
- **Recanting by the victim.** Elder victims are highly likely to recant their accusation of sexual abuse. This is for many reasons, such as fear of retaliation (especially in care giving situations) or not being believed, placement in a nursing home and not wanting the perpetrator to suffer any consequences, especially when they are a family member. While frustrating, aim to keep working with the victim. If they understand that talking with the advocate does not mean legal action must be sought, it could offer the elder an opportunity to process the abuse.
- **Refusal to talk about the abuse.** It may take an elder much longer to open up about sexual abuse. Building rapport with an elder victim could take countless sessions and still leave an advocate feeling like little headway has been made. On the other hand, while clamping up about the abuse, an elder may share many intimate details and stories about his or her life. This may begin to feel like a waste of time, but any move from an advocate dismissing a victim's stories could hinder future work.

Counseling

Crisis-Safety Planning

Advocacy work for elders in crisis can be different due to a number of reasons. First, elders can be in unique living situations due to the need for care. If an elder is in a health care facility, the dynamics of crisis counseling are altered. Since research has indicated many elders tend to be sexually abused by caregivers or adult sons, there is a likelihood that the victim and perpetrator live together. This means the dynamics of abuse can resemble domestic violence situations where the victim is literally trapped. It also indicated that victims who experience long-term abuse may have feelings of attachment and love towards the perpetrator. Physical disabilities can alter movement—and a victim may not be able to get themselves to the hospital for rape treatment. Cognitive disabilities can leave the victim questioning the reality of abuse, and greatly speed up the progression of the disease.

Here are things to keep in mind when safety planning with elders:

- Victims may be eligible for compensation of losses through the Victim's Compensation Assistance Program. Go to www.pccd.state.pa.us and click on Victims for details and information or call 1-800-233-2339.
- Area Agencies on Aging have a wide variety of resources available to victims. If a perpetrator is a care victim, a protective service worker could arrange for another care provider so the victim would not have to leave their home. Being forced to move into a nursing home may be the biggest fear for some elders, so being familiar with the services offered through the county Area Agency on Aging will allow the advocate to offer practical solutions to elders and dispel fears.

Phone counseling

The situations an elder may be dealing with in crisis could be quite different than those of younger victims, and the telephone may be his or her only connection to your center. An elder may have a physical or cognitive disability that affects access to transportation. An elder may live with or be reliant on the perpetrator for care and thus unable to obtain emergency care. Also, an elder victim may be too ashamed to talk face to face with anyone about his or her sexual victimization and the telephone may be an advocates only method of communication.

Group Counseling

Elders have been found to react both negatively and positively in the group counseling atmosphere, although most of this research has been done in the domestic violence field. Some elders responded well to being in a group of younger and middle-aged survivors, and took on the role of "mother" to the group. Others responded that they could not relate to their fellow group members because being aged changed the issues so much—career, child care, etc. did not matter as much and was replaced by care giver, disabilities, etc.

An elder victim, while more likely to have genital trauma, is also more likely to resist treatment and evidence collection. Assistance may be required for supporting the elder's legs during the inspection. Legs that are contracted from muscle atrophy require gentle pressure for abduction from assistants. Severe contractures may require the legs being held upwards toward the ceiling in order to accomplish external visualization. The fragility of skin and the lack of estrogenized vaginal tissues require very careful handling of the elder's body. Also, a small pediatric speculum is recommended for the internal examination.

(Dr. Ann Burgess for PCAR, 2004)

When the Victim is Incapacitated

An incapacitated person is an adult whose ability to receive and evaluate information effectively and communicate decisions in any way is impaired to such a significant extent that she or he is partially or totally unable to manage his or her financial resources or to meet essential requirements for his or her physical health and safety. (20 Pa. Cons. Stat. Ann. § 5501.4) Keep in mind that people with a cognitive disability such as Alzheimer's may still be able to grant consent depending on the progression of the disease.

Knowing or suspecting a victim is incompetent can be one of the most difficult ethical situations for advocates and care providers alike. If a victim is incapacitated, how can they make the decision to have the forensic rape exam? Most hospitals will complete the exam because providing medical treatment and treating injury in emergency situations is generally held up in court.

Another dilemma may occur when an individual close to the victim does not want the exam to be done and claims power of attorney or guardianship to prevent treatment. This can be for any number of reasons, but this individual could also potentially be the perpetrator. The following information will help an advocate understand the legal powers of guardianship and power of attorney.



Medical, Police and Court Advocacy

Medical Advocacy

In crisis mode, getting an elder victim to the hospital may be more difficult than a younger victim. An elder may be physically unable to get to the hospital, incapacitated and not know to seek medical treatment, or may not want to seek medical treatment for any number of reasons including guilt, shame, and embarrassment.

Forensic Exam:

Information to share with the nurse completing the forensic rape kit

Evidence collection may be different in the elder than in the adult victim. One medical study was done on the medical implications of an elder, and found the effects to be much more profound than on a younger victim.

Fifty-two women age 55+ who sought treatment at the Memphis Sexual Assault Resource Center in Shelby County, Tennessee from January 1987 to September 1990 participated in a study, with the following results:

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



Muram, D. Miller, K, and Cutler, A. (1992). Sexual Assault of the Elderly Victim. *Journal of Interpersonal Violence*, 7(1): 70-76.

A basic rule for nurses is to complete as much of the kit as possible, without the expectation that you will be able to gather as much evidence or receive the same cooperation with a younger victim. Also, always make sure everything in the kit is done with the consent of the victim; never with the use of force or drugs. Please see the next section for information on how to handle medical treatment when the victim is incapacitated.

Communicating With Older People

Communicating with older people often requires extra time and patience because of physical, psychological, and social changes of normal aging. Even more effort is needed in nursing homes where 60 to 90 percent of residents may actually have communication disabilities. Here are some tips:

- Before you begin your conversation, reduce background noises that may be distracting (turn off the radio or TV, close the door, move to a quieter place).
- Begin the conversation with casual topics (the weather, what the person had for lunch). Avoid crucial messages at the beginning.
- Continue conversation with familiar subjects such as family members and special interests of the person.
- Stick to a topic for awhile. Avoid quick shifts from topic to topic.
- Keep your sentences and questions short.
- Give the older person a chance to reminisce. Their memories are important to them.
- Allow extra time for responding. As people age, they function better at a slower tempo. Don't hurry them.
- Give the person choices to ease decision-making ("Do you want tea or coffee?" rather than "What do you want to drink?")
- Be an active listener. If you're not sure what is being said, look for hints from eye gaze and gestures. Then, take a guess ("Are you talking about the TV news? Yes? Tell me more. I didn't see it.")
- Make good use of verbal and nonverbal communication techniques. This is especially helpful when working with people who have various degrees of vision and hearing deficiencies.

A 77-year-old victim of the Belmont Shore, California rapist was a cancer survivor with a colostomy bag testified that she was sleeping in her easy chair when she awoke suddenly to someone grabbing the crown of her head. She thought it might be an animal and tried to squirm around only to note the hand got tighter. He led her into the bedroom and raped her and told her to relax and enjoy it. The victim testified that the rapist spoke kindly, asked her about her life, offered her a glass of water at one point, and tucked her in before he left. Two weeks later the rapist returned and raped her in her bed. He had disconnected her motion-detecting lights as well as her phone lines. The victim did not report the first rape due to fear and shame, but did report the second rape. The jury acquitted the defendant for the first assault claiming no DNA but convicted for the second rape where there was DNA to match to the rapist. This serial offender was charged and convicted of the rape of 14 women, ages 39 to 77, over a five year period.

Source:

www.asha.org/public/speech/development/communicating-better-with-older-people.htm



Rape Trauma Symptoms and Elders

Victimized elders have been noted to exhibit rape-related trauma symptoms of becoming fearful of the location of the rape, e.g., bathrooms, showers; fearful of males and male caregivers if assaulted in a nursing home; experience flashbacks, e.g., there is a boy in the closet; be easily startled, e.g., hyperarousal symptoms. They also will exhibit general symptoms of traumatic stress (e.g., fear, confusion, hypersomnia, lack of appetite, withdrawal), and an exacerbation of symptoms related to existing physical and/prior mental conditions.

Elders with the presence of a preexisting cognitive deficit, such as a dementia, may have delay in information processing and impaired communication which potentially compounds the trauma of the sexual assault. The vulnerability of an elder due to physical and emotional fragility places victims at unusually high risk for severe traumatic reactions to assault. Elder victims simply are not equipped, either physically, constitutionally, or psychologically, to defend against and cope with the proximal effects of sexual assault. One 87-year-old nursing home resident with severe dementia, raped by an attendant, would cry constantly for weeks following the assault. Only her daughter's presence helped to relieve the sobbing.

When a Queens, NY woman read about a man assaulting two elder patients in their hospital beds, she reported it was like reliving her own nightmare. She told a friend she thought it was the same man who assaulted her mother, then 79, in her bed at a New York Medical Center. The man had been taken into the hospital as a patient and admitted to the narcotics unit. Somehow he escaped from his bed and was lost for nearly an hour before hospital officials found him, dressed in scrubs in her mother's room. When her mother attempted to resist his attempts to abuse her, he slapped her face. The woman was quoted in the newspaper as saying, "Maybe when you are younger, you are more resilient, but my mother was never the same after that. She had nightmares three times a week until she died." The woman said her mother was subjected to over a dozen interviews with police, district attorneys, and hospital staff after the assault. The daughter wondered if it hastened her developing senility. She added, "I live with the guilt because I put her in the hospital originally." She also bemoaned the lack of support groups and organizations to address the problem.

Rape trauma syndrome, which includes both acute and long-term symptom responses to traumatic sexual assault, has two distinct variations: compounded rape trauma and silent rape trauma. In compounded rape trauma, victims have a past and/or current history of psychiatric, psychosocial problems that compound the effects of the sexual assault. In silent rape trauma, expression of assault-related symptomatology is muted, undetected, or absent. Elder sexual abuse victims are subject to both compounded and silent rape trauma.

(Dr. Ann Burgess for PCAR, 2004)

Intervention for Family Members of Sexually Abused Elders.

Family members need help when an elder is sexually abused whether it happens when the elder is living alone, living in assisted-living or living in a nursing home. It is common for family members to feel guilty when an elder is sexually abused. They often feel responsible for decisions made for the elder, especially if she or he is in a nursing home. The advocate can explore with the family member the decision for the living situation of the elder, whether it is independent, assisted or dependent living. Sometimes family members feel doubly guilty because the elder is in a nursing home and then the elder is raped. The exploration of this guilt in terms of realistic parameters is best accomplished in a support group setting and is an important part of counseling. There are care provider support groups for people who have to make decision to put a family member into a nursing home. Contact your local Area Agency on Aging to see if there are any groups in your area.

Outreach by sexual violence advocates would be critical for intervention both for the wife in the new nursing home and the husband for a family member support group. There was no service available in his state and arrangements were made for him to talk by telephone to another family member of a resident-on-resident nursing home sexual abuse case.

(Dr. Ann Burgess for PCAR, 2004)



A husband of 44 years made the difficult decision to place his 64-year-old wife in a nursing home, as he was unable to care for her due to a developing dementia and her increasing agitation. Three months after her admission, the husband received a telephone call from a discharged employee stating her conscience was bothering her knowing that information was being withheld from him. The employee went on to relate that the wife had been sexually assaulted by another nursing home resident. When the husband inquired about the incident, the executive director told him that patients are allowed to hug, kiss and fondle each other, even to the point of sex. When the husband talked directly to the care manager he learned that his wife and the male resident were both found nude in bed and the male penetrating his wife. The husband argued it was rape (not consensual sex) given the fact that his wife could not dress or undress herself and could not get into bed by herself. The husband immediately removed his wife from the nursing home and contacted the state Ombudsman office and police to report the rape. Unfortunately, the case lacked forensic evidence and witnesses for a criminal case, but a civil suit was pursued and a settlement reached against the nursing home.