



# SEXUAL VIOLENCE IN LATER LIFE

## A TECHNICAL ASSISTANCE GUIDE FOR ADVOCATES

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# SEXUAL VIOLENCE IN LATER LIFE

## A TECHNICAL ASSISTANCE GUIDE FOR ADVOCATES

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

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

Sexual violence against people in later life is a form of elder abuse. The National Center on Elder Abuse defines elder abuse as the victimization of an older person "by someone who has a special relationship with the elder (a spouse, a sibling, a child, a friend, or a caregiver)" or that occurs "in residential facilities for older persons (e.g., nursing homes, foster homes, group homes, board and care facilities)." Studies show that older people are sexually assaulted in their homes (or domestic

settings) as well as in institutional settings such as nursing homes or other care facilities (Burgess, Ramsey-Klawnsnik, & Gregorian, 2008; Ramsey-Klawnsnik, Teaster, Mendiondo, Marcum, & Abner, 2008).

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

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

## PREVALENCE OF SEXUAL VIOLENCE IN LATER LIFE

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



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

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

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

## AGE, GENDER, AND OTHER DEMOGRAPHIC ISSUES

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



## SIGNS AND SYMPTOMS

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

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

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



## TYPES OF SEXUAL OFFENSES

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

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

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

## PERPETRATORS

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



## ILLUSTRATIVE CASES OF SEXUAL VIOLENCE AGAINST PEOPLE IN LATER LIFE

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

### Intimate Partner Sexual Violence

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

This case illustrates long-term, multi-faceted intimate partner violence in which the victim was silent about her assaults until a caring person sought assistance for her. Despite Mrs. V.'s long

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

### Incest

#### Adult child offenders

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

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

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

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

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

### *Other relative offenders*

*Mrs. J. is eighty-six years old. She moved into the home of her daughter and son-in-law to recover from a broken hip. Several months later, her daughter died and her son-in-law, Charlie, became her caregiver. Mrs. J. disclosed to her visiting nurse that Charlie took nude photos of her. He instructed Mrs. J. to open her legs and smile for the camera. He told her that he needed the photos to have evidence that he had not abused her and that her daughter would want her to cooperate.*

*Charlie also told Mrs. J. that as a care provider he needed to "check" her genitals, which involved him pushing something large in and out of her vagina. The nurse filed an elder abuse report triggering criminal and Adult Protective Services investigations, as well as an arrest of Charlie and intervention services for Mrs. J. It was learned that Charlie earned his living as a home health aide (excerpted from Ramsey-Klawnsnik, 2003).*

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

### **Institutional Sexual Violence**

#### *Care facility staff offenders*

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



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

It is important to remember that older males are also at risk of sexual assault, particularly when they have disabilities. Despite the presence of compelling medical evidence, this perpetrator was criminally charged only with physical assault. Additionally, male victims may experience compounded barriers to reporting sexual violence and to being believed due to general thinking that

sexual violence is a “woman’s issue.” Social stigma attached to sexual victimization among males may be higher than for females, especially in certain cultural groups with more traditional definitions of masculinity. All of these factors can contribute to underreporting of sexual violence among males.

### **Resident offenders**

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



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

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

### **Acquaintance Sexual Violence**

*Ms. P., a sixty-four-year-old woman with long-term schizophrenia, was admitted to a state mental hospital due to active psychosis. She disclosed to a nurse that just before her admission that a neighbor sexually assaulted her. The nurse was tempted to attribute Ms. P.’s statements to her psychiatric condition, but charted them, notified the treating physician, and reported to law enforcement. The registered nurse (R.N.) requested that the physician order an exam by a Sexual Assault Nurse Examiner (SANE). The*

*police initially believed the report to be without merit, however, DNA evidence was found during the exam. A criminal records check revealed that the neighbor had a history of conviction for sexual assault. While initially it appeared that the disclosure was merely a result of a psychotic episode, evidence suggested that in fact the sexual assault had triggered Ms. P.’s decomposition*  
(excerpted from Ramsey-Klawnsnik et al., 2007).

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



## SPECIAL ISSUES FACING OLDER VICTIMS OF SEXUAL VIOLENCE

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

### Aging Issues

Normal physiological changes occur as people age. These include changes in memory and sensory abilities such as sight and hearing. Advanced age brings declines in dexterity and mobility, lowered immune functioning, and changes in the functioning of virtually every body organ. Bones become more brittle, skin more fragile, and tissue more easily damaged. Older people are more easily injured and heal much more slowly than younger adults. They typically process information more slowly than younger people because of age-related changes in

## OLDER ADULTS WERE RAISED IN A SOCIETY VERY DIFFERENT FROM THAT OF TODAY.

brain functioning. Normal physiological changes put people in later life at elevated risk of many chronic conditions including arthritis, hypertension, heart disease, and diabetes. Additionally, the likelihood of becoming disabled escalates. These factors can reduce self-care abilities, increase dependence upon others and vulnerability to interpersonal violence, and increase the severity and consequences of injuries sustained.

### Generational Thinking

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

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

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

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

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

### **Mandated Reporting Requirements**

Throughout the nation, legislation requires certain individuals to report alleged elder abuse, including sexual assault, to state authorities. The purpose of reporting laws is to protect victimized elders who are unable to independently seek assistance. Legal requirements mandate that professionals report any form of suspected elder abuse, including sexual

assault, to Adult Protective Services (APS) and in some cases, also report to other state authorities such as Departments of Public Health. Typically health care, criminal justice, social work, aging services, and other professionals are mandated to report suspected cases to APS. In institutional cases, reports to state Departments of Public Health and licensing authorities are usually required. Reports to long-term care Ombudsman offices may also be required and/or helpful. Laws vary somewhat from state-to-state. It is critical that advocates know and follow applicable reporting laws. Information about reporting laws can be obtained from APS programs, Departments of Public Health, or legal consultation.





## PRIMARY PREVENTION OF SEXUAL VIOLENCE AGAINST PEOPLE IN LATER LIFE

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

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

### **Prevention at Individual and Relationship Levels**

Providing outreach to people in later life and increasing their awareness about sexual violence is an important step towards prevention. Creating and disseminating sexual assault awareness materials geared towards older adults, including public service announcement, are ways of increasing awareness. Presentations at senior centers and other places where people in later life gather can be important means of making contact. Gaining an understanding of where people in later life

gather and find support in your community and developing collaborative partnerships and educational opportunities with those groups can be an important prevention strategy. This may include senior centers, clubs, and faith-based organizations.

## PRIMARY PREVENTION MEANS PREVENTING SEXUAL ABUSE BEFORE IT OCCURS

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

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

## Prevention at Community Levels

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

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

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

Employees and volunteers should be part of an education and awareness campaign on sexual violence against people in later life as well as bystander intervention so if they observe or

witness abuse, they can effectively intervene. All facility staff must be trained in residents' rights, all forms of abuse against people in later life, signs and symptoms of sexual assault, measures to protect actual and potential victims, the duty to report alleged assault, preserving assault evidence, and accessing sexual assault exams and other services for alleged victims.

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

## Prevention with Larger Society

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

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







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

Preventing perpetration in later life poses a challenge. Research and prevention strategies are still in infancy with regards to the primary prevention of sexual perpetration among older offenders. It is critical that early intervention occur with perpetrators, at the beginning of the life span

as way to prevent ongoing sexual offenses against multiple victims over many years. Challenging the myths that surround sexual violence as a crime of passion rather than a crime of violence is critical in raising awareness about sexual violence against people in later life. Social norms that promote healthy and respectful relationships and communications across the lifespan are also key components of the prevention of sexual violence in later life.

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



## ROLE OF ADVOCATES IN PRIMARY PREVENTION OF ELDER SEXUAL ABUSE

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

### How Advocates Can Help

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

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

Sexual assault centers can be more user-friendly for people in later life when such centers are accessible both structurally and attitudinally to older adults. People in later life may be uncomfortable discussing highly private matters with very young advocates. When staff and volunteers represent a variety of ages, older victims may feel more at ease. Understanding this, advocates can prepare to help older victims move past paralyzing feelings of self-blame and

shame through counseling, support groups, and psycho-education. Further discussion of this topic is provided in Vierthaler (2008). See California District Attorneys Association (CDAA, 2003) training video for suggestions on interviewing and working with elder victims.

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

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

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

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

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

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

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

## CONCLUDING THOUGHTS

Advocates and allied organizations can work together to prevent sexual violence against people in later life and to ensure that older adults are no longer forgotten victims of sexual assault, are not left unprotected from continuing assaults, and are not deprived of sexual assault services. The physical and psychosocial impact of sexual assault on older adults is often missed, minimized or ignored. Many people in later life have not been protected from ongoing assaults even after victimization has been recognized. Older victims are infrequently offered forensic exams or sexual assault counseling. Education and advocacy can help to ensure that hospital personnel, investigating police officers, and prosecuting

attorneys are better equipped to identify and prevent sexual violence and to accommodate the special needs of older victims. Partnering with services that assist victims in later life can bring the expertise of sexual assault advocates to victims. For example, many communities have multi-disciplinary elder abuse teams (discussed in Brandl et al., 2007) consisting of representatives from APS, health care, law enforcement, and other services. The purpose of the teams is to bring together needed expertise and provide a coordinated and effective response to older victims of sexual and other forms of violence. A sexual assault advocate is an invaluable member of such a team.



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## GLOSSARY

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

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

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

**Decompensation** - the deterioration of existing psychological defenses in an individual

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

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

**Elder** - a person of age 60 years and beyond

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

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

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

## NATIONAL SEXUAL VIOLENCE RESOURCE CENTER

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

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Dr. Holly Ramsey-Klawnsnik is a Licensed Marriage & Family Therapist, Licensed Certified Social Worker, and researcher. She provides training, consultation, research, and writing services for law enforcement, health care, domestic violence and sexual assault coalitions, and Adult Protective Services systems. She has conducted multiple studies on sexual violence in later life and authored over 70 articles, book chapters, and training manuals.



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NATIONAL ADULT PROTECTIVE  
SERVICES ASSOCIATION

THE NATIONAL APS RESOURCE CENTER

## Technical Assistance Brief January 2015

### Investigation Protocols

*Holly Ramsey-Klawnsnik, PhD*

*NAPSA/NAPSRC Director of Research*



The National Adult Protective Services Resource Center (NAPSRC) provides monthly Technical Assistance (TA) calls on subjects requested by the field. Our team of adult protective services (APS) experts provides this national TA to state APS administrators. This brief summarizes the information provided during the January 2015 call.

The NAPSRC has received multiple requests for technical assistance regarding investigation protocols. In the 2014 survey completed by APS administrators it was among the top five TA needs identified. Additionally, about one-third of the states that requested in-depth TA during the 2013-2015 Resource Center cycle asked for help on this topic. In partial response to these requests, this brief addresses the framework that APS programs need to provide to guide investigators. This framework, or protocol, also guides supervision, quality assurance, and other

program measures that oversee investigations. Investigation protocols are typically provided in the form of APS regulations, policies, and operating procedures and must be consistent with state laws governing the program.

The NAPSA Recommended Minimum Program Standards (NAPSA, 2013) provide guidance in crafting and revising investigation protocols. These standards define a protective services investigation as, "A systematic, methodical, detailed inquiry and examination of all components, circumstances, and relationships pertaining to a reported situation." They call for APS programs to have, "a systematic method, means, and ability to conduct and complete investigations in a timely and efficient manner to determine if reported abuse has occurred, and if services are needed."

The standards further call for APS programs to: make a determination of the veracity of the report including whether maltreatment has occurred, have a systematic method for making that determination and recording findings, and substantiate the report or not based upon careful evaluation of all investigation findings. Investigations must be conducted consistent with the NAPSA Code of Ethics, a key principle of which is, "... persons... who are victims of mistreatment should be treated with honesty, caring, and respect" (NAPSA, 2004).

To implement these standards, APS programs must have policies in place that address the various components. A procedure for receiving reports in a consistent and timely

#### **About the National Adult Protective Services Resource Center (NAPSRC)**

The National Adult Protective Services Resource Center (NAPSRC) is a project (No. 90ER0003) of the Administration for Community Living, U.S. Administration on Aging, U.S. Department of Health and Human Services (DHHS), administered by the National Adult Protective Services Association (NAPSA). Grantees carrying out projects under government sponsorship are encouraged to express freely their findings and conclusions. Therefore, points of view or opinions do not necessarily represent official Administration on Aging or DHHS policy.

manner statewide must be established along with reporting criteria and an intake protocol. Criteria and a method must be in place for determining whether reports will be screened in for investigation or screened out, perhaps with referral to another program. Triage criteria to assess the urgency of needed response and required timeframes for commencing and completing investigations are needed. Required investigation components must be delineated to guide staff in conducting thorough assessments of abuse allegations and the client's safety. Established procedures for APS reports to other authorities such as law enforcement are also needed.

Essential supervision throughout the investigation should be spelled out in the form of "required supervisory junctures" or specific decision-making points at which investigators must receive and document the guidance and approval of their supervisors for key decisions.

Investigation policies and procedures must be clear and consistently applied throughout the program. It is also essential to build in room for clinical judgment and pathways for investigators to obtain management approval to deviate from standard procedures when required to preserve safety and implement the ethic of "do no harm." To illustrate, while a visit to the home of the client is an integral investigation step, sometimes this is impossible or contra-indicated. For example, a client who hoards and is profoundly embarrassed or fearful of allowing an investigator to enter the home may be willing to meet at a local coffee shop. This meeting may facilitate assessment of the client's condition and rapport building so that a home visit eventually occurs. As another example, an APS worker insisting upon visiting a victim of domestic violence in her home could exacerbate danger by enraging a controlling and suspicious perpetrator.

While unannounced visits are often essential in determining client risk level, in some circumstances they can trigger a crisis for the victim and potentially the investigator, particularly if the abuser is present. Well-informed investigation protocols identify normal procedures AND create mechanisms through which trained personnel can obtain management approval to tailor those procedures, based upon evidence, to protect safety.

Assessment tools utilized to assess client functioning must be valid, reliable, and standardized and used for their intended purpose. Investigators should not use tools unless they are specifically trained and authorized to administer, score, and interpret them. Formal evaluations, such as capacity evaluations conducted by

### **Recommended Minimum Program Standards call for investigations to include:**

1. An assessment of report information to determine danger to client and the urgency (or triage level) with which the investigation should commence
2. A method for assessing potential danger to the assigned investigator
3. A visit to the client's home during which the investigator will respond to emergencies
4. Interviews with the reporter, client, collaterals, family, the alleged perpetrator(s) and relevant others
5. A review of relevant documents such as police reports and medical records
6. A needs and risk assessment to systematically screen the client's physical health, functional ability, mental health status and capacity, formal and informal supports, environment, and finances.
7. An assessment of the alleged perpetrator(s) to ascertain risk to the client's safety and independence. (This component obviously does not apply in self-neglect cases, although all other information does.)

*From NAPSA Recommended Minimum Program Standards.*

## Investigation To Do List

- Determine if report is accurate
- Determine if client is at risk
- Assess client's over-all care, condition, abilities, and limitations
- Screen for unreported maltreatment
- Document all findings including unsuccessful attempts to collect information
- Offer needed emergency/crisis intervention
- Use supervision to plan and conduct required steps, analyze findings, and draw conclusions
- Comply with program policies and standards.

trained specialists, should be arranged when indicated (see Ramsey-Klawnsnik, 2014 for a discussion of cognitive assessment tools and procedures).

To conduct thorough and effective investigations that accurately assess the veracity of the allegations and client risk level, investigators need to know forensic principles, or methods of collecting and documenting evidence in an objective, logical, and accurate manner. They also require the ability to build rapport, conduct skillful interviews, analyze information gathered, and document essential findings. Worker compliance with regulations is absolutely essential, including applying abuse definitions and required response times, key steps, completing required forms and documentation, and using supervision.

State investigation protocols need to delineate the specific steps that are typically required to investigate alleged maltreatment and reflect that these steps need to be carried out in a logical order.

During planning review the reported and known information and identify the triage level and required response time. Strategize steps to be taken to mitigate safety risks to client and investigator. Identify people to interview and records to review. Determine sequence and method of accessing information sources and create a list of information needed from all sources. Revise the plan as the investigation proceeds based upon findings.

Providing principles and techniques of investigative interviewing is beyond the scope of this brief. It is imperative, however, that APS programs provide adequate training for investigators in interviewing alleged victims, people with disabilities, alleged perpetrators, and relevant collaterals. Close supervision is needed to help investigators prepare for these challenging and sensitive interviews as well as analyze findings following interviews. There are sources of information available regarding investigative interviewing skills, including the Academy for Professional Excellence elearning APS courses, Ramsey-Klawnsnik, 2004 a & b, 2005 a & b; and Ramsey-Klawnsnik & Klawnsnik, 2004. It is important that investigators recognize that throughout all interviews sensory perceptions (what they see, hear, smell, etc.) are important data to be factually documented along with verbal findings.

Analyze collected data to determine its relevancy to the allegations. Consider conditions under which data was provided. For example, a hospitalized client who is interviewed the day following surgery is expected to demonstrate cognitive ability below that person's norm due to trauma and medications. Consider which specific findings support and refute each allegation, if there is missing information (for example, banking records), if missing data can be obtained, and the impact of missing data on conclusions. Review state abuse definitions and accumulated evidence to determine which allegations, if any, to substantiate. Protocols should establish a standard of evidence to be applied when investigation conclusions are reached. Typically APS programs apply the "preponderance of evidence" standard requiring that at least slightly more than half of the evidence supports an allegation to substantiate it. This standard is very different from the "clear and

convincing” and “beyond a reasonable doubt” standards typically applied in criminal situations. For a discussion of evidence standards, see Heisler, 2014.

Another essential element to address in state investigation protocols is documentation requirements. Individual case records should reveal:

- The specifics of allegation(s) made in the report
- Agency action taken (screen in or screen out report for investigation and triage level if accepted)
- All casework decisions made and the rationale for these
- Action steps taken to investigate
- The findings from these steps
- Worker/supervisor analysis of these findings
- Conclusions or substantiation decisions reached
- Interventions offered during the investigation and the outcome (whether or not accepted, if

### About the Author

Dr. Holly Ramsey-Klawnsnik is a sociologist researcher, Licensed Marriage & Family Therapist, and Licensed Certified Social Worker. She has provided secondary prevention services to older adults and adults with disabilities and conducted forensic evaluations and investigations for APS and court systems. She has presented continuing education programs for Adult Protective Services systems, regulatory and law enforcement agencies, health care providers, the judiciary, and domestic violence and sexual assault coalitions. Her research and practice have focused on investigating alleged abuse, interviewing skills, casework intervention and supervision, mental health and mental capacity, self-neglect, domestic violence and sexual assault in later life, and victimization in facilities. Employing quantitative and qualitative methods, she has researched APS case handling procedures and outcomes. She has authored journal articles, book chapters, training curricula, technical assistance materials, and professional reports and has also developed caseworker and supervisory training manuals for multiple APS systems. Holly has served as a contracted trainer and consultant for APS and regulatory systems nationwide. Her work on federal projects includes those funded by the U.S. AoA, CDC, NIA, NIJ, OVC, and OVW.

### Typical Investigation Steps and Sequence

- Plan the investigation
- Contact the reporter to confirm information received
- Observe and attempt to interview the client
- Collect collateral data such as information from care providers and relevant records
- Interview the alleged perpetrator(s)
- Analyze all findings
- Make substantiation decisions
- Accurately document investigation steps and findings in a timely manner
- Respond to emergencies throughout

accepted or arranged through court order, the impact of that intervention).

Documentation needs to reveal that agency policies and procedures, ethical principles, and relevant laws were followed throughout the investigation and that supervision occurred at key casework junctures.

An effective and thorough investigation protocol is essential for APS programs. This protocol guides the work of staff and is directly related to the quality of investigations conducted. Of course, having a protocol in place is not sufficient to insure adequate investigations. Investigation quality is also intricately linked to staffing patterns, hiring procedures, basic and ongoing staff training provided, supervision and administration provided, professional consultation available to investigators, quality assurance measures in place, the documentation system in use, and program relationships with community partners including law enforcement and health professionals. Internal consistency among APS program components is also needed. For example, timelines for investigation completion must be consistent with caseloads. (See Ramsey-Klawnsnik & Teaster, 2012 for a

discussion of APS programmatic issues affecting investigation quality).

The quality of investigations conducted by an APS program determines the appropriateness and effectiveness of the interventions that the program can provide. Investigation quality is also linked to the degree to which clients and the public are well-served by the program, community perceptions about the program, staff morale, and the outcome of hearings and appeals that may follow investigative decisions.

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# Polyvictimization in later life: trauma-informed best practices

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In this article

## Abstract

This article provides a summary of salient trauma findings and conveys the dearth of research pertaining specifically to the trauma of elder abuse. This material, in conjunction with information contained in other articles composing this special issue, lays the foundation for advancing a trauma-informed approach to assisting

older adults who have experienced polyvictimization. Informed by the findings presented and their extensive clinical experience with victims of violence, the authors suggest steps for providing a trauma-informed and victim-centered response to older adults who have suffered polyvictimization. These steps are then illustrated with an in-depth late life polyvictimization case analysis.

KEYWORDS: Late life polyvictimization, elder abuse, trauma, trauma-informed care, older victim-centered intervention

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In 2012, the National Committee for the Prevention of Elder Abuse received an award from the Office for Victims of Crime, Office of Justice Programs, U.S. Department of Justice, to advance knowledge and enhance awareness of polyvictimization in later life. Goals of the grant were to explore the existing research and practice literature in order to develop a definition of polyvictimization in late life, hold a national forum on polyvictimization, develop web-based training curriculum (Ramsey-Klawnsnik et al., 2017) and a special issue of JEAN (Teaster & Roberto, 2017). An article in the special issue on older adults (Ramsey-Klawnsnik, 2017) presents data extrapolated from elder abuse

research that lays a foundation for applying a trauma-informed approach to polyvictimized older adults.

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## **Links between trauma and late life polyvictimization**

Trauma is an event (or series of events) that shatters an individual's sense of safety in the world and overwhelms his or her ability to adapt. Single incident events, such as natural disasters, motor vehicle accidents, and stranger assault have all been recognized as potentially inducing a trauma response, as have chronic circumstances such as partner and child abuse and war (Briere & Scott, [Briere & Scott, 2012](#)). Elder abuse, as a specific kind of trauma, is insufficiently discussed in the literature despite the disproportionate risks for victimization and polyvictimization that many older adults may face (Goldstein, [Goldstein, 1996](#)).

Research regarding younger people has revealed several key trauma findings: (1) the impact of trauma is cumulative, and (2) victims of interpersonal violence (as opposed to traumatic events that do not involve human cruelty) are disproportionately likely to be revictimized (Classen, Palesh & Aggarwal, [Classen, Palesh & Aggarwal, 2005](#)). These concepts of trauma as both cumulative and often recurrent are particularly relevant to older adults. As one ages, the likelihood of having survived a traumatic event, indeed multiple traumatic events, increases. The statistical likelihood for revictimization grows. The impact of aging on trauma is complicated; the “additive negative effects of multiple trauma exposures on older adults is clear” (Averill & Beck, [Averill & Beck, 2000](#), p. 51).

Work with older adults must also consider historical trauma: the “cumulative emotional and psychological wounding over the lifespan and across generations,

emanating from massive group trauma experiences” (Yellow Horse Brave Heart, [2003](#), p. 7). Slavery, colonialism, genocide, racism, and ableism are examples of communal and historical trauma, creating lasting ripple effects for individuals, families, and communities. Historical trauma may affect older adults in several ways. The first is the communal trauma that older adults may carry from their own lives, for example, memories of the Holocaust, the boarding school experiences of American Indians, Japanese American internment camps, racial segregation in the Jim Crow South, and periods where women were disenfranchised and domestic and sexual violence went largely unrecognized. In addition, older adults from various generations, faiths, and countries may carry the historical trauma experienced by their parents, grandparents and larger communities. Historical traumas resonate in the lives of many older adults and can be “reactivated” by current experiences of injustice, or even watching children and grandchildren experience the same developmental life stages as when an older adult first suffered the trauma.

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## **The subjective nature of trauma**

What is “traumatic” is to a certain extent subjective (Rasmussen, Rosenfeld, Reeves, & Keller, [2007](#)). The events older adults may experience as traumatic are not often recognized in the literature and may go unacknowledged if service providers and caring family members are not alert to the subjective nature of trauma (Averill & Beck, [2000](#)). For example, “being ... given the wrong or excessive medications is often perceived as a severe trauma by elderly persons” whereas this might be perceived as far less traumatic and harmful by a younger person (Goldstein, [1996](#), p. 133). Similarly hospitalizations and illness have been



observed to precipitate traumatic responses in older adults (Aarts & Op Den Velde, [1996](#); Averill & Beck, [2000](#); Sadavoy, [1997](#)). The individualized nature of trauma may be particularly significant for elders who are dependent on others such as those who have a physical disability or cognitive challenges.

Older adults may carry victim-blaming attitudes due to early socialization experiences. This may aggravate post-traumatic responses for older victims who blame themselves rather than the perpetrator (Falk, Van Hasselt, & Hersen, [1997](#)). Very importantly, older adults harmed by loved ones (i.e., adult children and grandchildren) may experience far more psychosocial trauma than peers harmed by individuals at a greater social distance, such as paid care providers or fellow residents in care facilities. "Assault is more psychologically injurious when inflicted by someone expected to provide love, protection, and support" (Ramsey-Klawnsnik, [2003](#), p. 57).

## **The Health Impact of Trauma**


There is substantive evidence that trauma has profound impact on physical and mental health. Much of this research fails to focus upon or include older adults, although that is rapidly changing (Dong & Simon, [2013](#)). This is important at all points in the lifespan, but perhaps particularly so for older adults, as signs of trauma can be confused or conflated with physical and mental health conditions. For example, "The lack of data regarding PTSD in the elderly may be due to complicated presentation. Older adults often present with comorbid diagnoses and may underreport symptoms, or the symptoms may be masked by other diagnoses" (Ladson & Bienenfeld, [2007](#), p. 48). It is also worth noting that dementia can mimic signs of complex PTSD. Withdrawal, agitation, memory loss, difficulty with problem solving, disorientation in time or space, verbal aggression,

difficulty sleeping, and clingy or childlike behavior may all be signs of both dementia and trauma in older adults.

Given that the impact of trauma is cumulative, chronic traumas, multiple traumas over the lifespan, and historical traumas may all intersect and compound one another in the **lives** of older adults, creating unique challenges for polyvictims and opportunities for perpetrators.

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## **Defining best practice & trauma-informed care**

Emerging research, including prevalence rates of violence and polyabuse towards older adults, make the case for what is already the consensus best practice standard for younger survivors: victim-centered, trauma-informed care. Trauma-informed care “is a strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and victims, and that creates opportunities for victims to rebuild a sense of control and empowerment” (Hopper, Bassuk, & Olivet,  2010, p. 82). This approach prioritizes victims’ needs for safety, respect, and acceptance and maximizes victim choice and control. Victim strengths are validated and serve as the foundation for future growth. Interventionists recognize that trauma has a significant impact on coping strategies and that victims may employ substance use, cutting, eating disorders, and dissociative coping as survival skills to deal with toxic stress. Partnership is the cornerstone of the victim-provider interactions and mutual self-help is encouraged. Opportunities for revictimization, especially by helpers and helping systems, are minimized.

A trauma-centered response takes a victim-centered approach emphasizing the needs, safety, privacy, and well-being of the victim. Responding professionals (police officers, APS workers, domestic violence counselors, etc.) are trained in trauma, relevant research and practice findings, and methods of fulfilling their roles in ways that do not further harm victims. They are trained to understand the impact of victim trauma and how it can affect victim behavior. Case-related activities are conducted in such a way as to prevent harm and discomfort to the victim. For example, during a police investigation of a case of alleged late life polyvictimization, the involved officers would limit the number of times a victim had to talk about the assault. Before the detailed investigative interview is conducted, first-responding officers and detectives would ask only the minimum number of questions to determine the nature of the allegation, arrange needed medical treatment, and secure any evidence, witnesses, and suspects. The victim is offered the support of an advocate (unless prohibited by law). The victim's privacy and confidentiality are maintained. In sum, a victim-centered response requires that the needs of the victim, not the needs of responding professionals or organizations are the foremost consideration during investigation and intervention. Similarly, the needs or desires of the alleged perpetrator or collaterals involved in a case cannot be the first consideration. Providing victim-centered response can be challenging given high caseloads and time constraints faced by professionals across disciplines responsible for responding to elder abuse.

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## **Suggestions for providing trauma-informed and victim-centered care**

1. Spend time with alleged victims before involved providers, family members, alleged perpetrators, or others involved in their cases.
2. Speak in a private and safe space and listen before you speak.
3. Introduce yourself and be clear about your role and the alleged victim's rights, including the right to refuse your services. Honor the older adult's "no". Building trust and healing trauma take time. The nature of trauma, and particularly trauma borne of interpersonal abuse, is that the survivor had little ability to say "no" – no I don't want to have sex with you, no I don't want to be spoken to in that way, no I don't want you to take my money. Providers plant a seed by honoring the older adult's "no".
4. Assume that the victim is mentally competent until there is significant evidence to the contrary. If cognitive limitations exist, this does not relieve providers of the responsibility to partner with that victim in whatever capacity the victim is able.
5. Reflect the language an older adult uses. Avoid words like violence, abuse, or criminal behavior if the victim does not initially conceive of what has happened as abusive or criminal. Use language and grammar that is neutral, non-intimidating, and easily understood.
6. Ask older adults about their goals and strengths before you ask about their challenges.
7. It may not be necessary to understand the nature of the trauma (particularly past traumas and/or multiple/chronic traumas) to do your job well and empower older victims to improve their own safety. Asking a survivor to relive past traumatic experiences by discussing them may do more harm than good.



Action can be taken to help a victim to safety without questioning him or her about history of childhood abuse or experiences of intimate partner violence in their early 40s, for example.

8. If an older adult volunteers' information about trauma history, do not squash their disclosures. However, be mindful of how long the conversation continues. Sharing one's traumatic experiences and having one's pain publicly witnessed and honored by another human being can be profoundly healing. However, reliving such experiences can also activate distressing physiological reminders of the event. Restoring healthy boundaries – including boundaries around time – is an essential foundation for healing from trauma. Seek to consensually limit how long the older adult focuses on the traumatic events.
9. Be mindful of your proximity to the older adult, body language, word choice, and tone of voice. Convey warmth, support, and concern for safety.
10. Acknowledge abuse disclosures and convey support without expressing horror, disbelief, or opinions about the perpetrator.
11. Ask permission before touching an alleged victim. If you are in a role in which physical examination, treatment, or care is to be provided, explain what you will do and the reason for it before asking for permission to proceed.
12. If you are younger than the person for whom you are providing services, find a balance between extending appropriate deference and respect and including the older adult as a peer. Be mindful of relevant, culturally specific expectations regarding interactions between older adults and younger members of the community.
13. Trauma interferes with sense of time. Be prepared to have victims miss or

forget appointments.

14. Trauma interferes with information processing – a challenge which may (or may not) be compounded by aging. Be patient with the victim and be prepared to repeat yourself.
15. Trauma can shut down the speech centers of the brain making it profoundly difficult for older victims to find language for what has happened to them. Victims may share sensory details – the color of someone’s shirt or the temperature of the room – that appear irrelevant. If there is concern about ongoing or recent violence follow these sensory details. The body remembers trauma where the brain cannot. Older adults in particular may have added difficulty verbalizing the nature of the trauma experienced. Pay attention to behavioral cues such as agitation, sudden onset of memory challenges, confusion, distress, anger, sexualized behaviors, or behavioral expressions of fear or ambivalence around specific people, places or things.
16. Trauma interferes with memory encoding. Be prepared for older victims to disclose abuse experiences with missing elements. Do not push if the victim cannot remember or find language for what has happened to them. Inability to remember can have a protective function.
17. Trauma’s impact on memory, speech, and executive function may cause the older adult victim’s abuse account to appear inconsistent or disorganized. In addition, the disclosure may change over time. Recognize that this does not mean that it is not true.
18. Some victims engage in “maladaptive” coping such as substance use or eating disorders. Reframe such behaviors as both normal, hardwired responses to

recurrent toxic stress and signs of creativity, adaptability, and strength. Avoid judging, shaming, blaming. Help victims recognize their coping strategy as a necessary survival skill in the face of trauma, while recognizing the significant health impact. Offer tools to develop beneficial coping skills (e.g., journaling, prayer for the faith-based, exercise, social connectedness).


19. Provide psycho-education about common responses to trauma, including mental, cognitive, and physical health impact, common coping mechanisms, and possible healthy coping mechanisms (e.g., mindfulness meditation, chair yoga, support group meetings).
20. Guide victims with harm reduction techniques specific to their coping strategies.
21. Recognize that work with victims can itself be traumatic. Practice good self-care.
22. Recognize the impact of trauma history on professional practice. Expand your circles of support around the intersections of personal trauma and the traumatic experiences exposed to in professional life.
23. Seek and apply trauma-informed supervision.
24. Work towards trauma-informed policies and protocols for your organization.
25. Recognize that physical, emotional, mental and spiritual safety for providers is the foundation of trauma-informed care for victims.

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## Illustrative case

Janet, age 92, has experienced leg amputation due to complications from diabetes. She has lived in an Assisted Living Facility (ALF) since her surgery. Early one morning, she wheeled herself to the dining room to await breakfast and found that other residents had not yet entered. Suddenly a male resident approached her wheelchair from behind. He inserted his hand into her blouse and under her clothing, grabbed and pinched her breast, and made obscene comments. Janet was shocked and felt profoundly violated - the assault was physically painful and left her stunned. She wanted to call out for help but could not. When she was able, she wheeled herself silently back to her room without eating and spent the day there alone - confused, afraid, and uncertain and foregoing meals and normal activities. An aide that she liked and trusted came on duty at 3 PM and approached Janet to inquire about her. Janet confided the event to the aide. The aide reported it to facility management. Management staff grilled Janet about her statements and demanded why she had not screamed or reported this to staff when it occurred. They told Janet that the man that she accused was from a good family and that he would not do such a thing. After questioning Janet and the named offender on three occasions, management made a legally required report to Adult Protective Services (APS) and the police. However, they did not believe Janet and they informed both APS and police representatives of this when they made the required reports. The responding police officer interviewed facility management, then Janet, and then the suspect. He told Janet that there was no point in pressing charges because it was basically a "he said, she said" situation. The APS investigator found Janet to be highly distressed and believed her account. However, APS unsubstantiated the report citing their



conclusion that no evidence supported Janet's statements. Since the event, Janet has refused to leave her room and has requested that meals to be brought to her. She is no longer socializing or attending her once-enjoyed activities at the ALF. She is very afraid to again encounter the resident who assaulted her (Ramsey-Klawnsnik,  2013, p. 1-2).

Cascading victimization occurs when one or more episodes of abuse trigger subsequent, additional forms of abuse inflicted by the same or other offender(s). Following Janet's disclosure of sexual assault, the facility staff inflicted cascading emotional abuse and caregiver neglect resulting in multifaceted harm to this victim. She was not offered the services of a forensically trained health care provider or intervention of any kind. She continued under the same roof as the man she described as abusing her sexually (molestation), physically (grabbing and pinching), and emotionally (shocking and frightening obscene comments). Afraid to again encounter him, Janet did not leave her room. She lived in fear, traumatized not only by the assailant, but also by those who did not believe her, failed to protect or assist her, and instead demanded why she did not scream or report immediately. She had no opportunity to speak with a supportive person about this traumatic experience. Her behavior changed markedly. She lost appetite and had difficulty sleeping. Her social support disappeared because she no longer socialized with her friends. In the year prior to this, Janet had been widowed and had endured leg amputation, lost mobility, and the need for facility care. She felt that assault on top of all of that was just too much to bear. Her desperation was complicated by old memories that surfaced since the assault. During Janet's childhood, teachers often reprimanded children by grabbing and pinching and she was repeatedly grabbed and pinched on her arms, face, and ears by angry teachers. When her parents later observed bruises, she was grilled

about getting into trouble at school and sometimes beaten by her father for bringing shame on the family. These memories tormented Janet since she was grabbed and pinched in the facility and then aggressively questioned, accused, and disbelieved. She suffered intrusive memories of male peers sexually grabbing her and making degrading remarks during her adolescence. Janet had not thought about those painful experiences for years, however, being assaulted in her care facility triggered these tormenting memories.

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## **A trauma-informed response to janet**

1. In a trauma-informed and victim-centered response the facility management would not “grill” Janet about her disclosure. They would not demand why she did not scream or report the incident sooner and would not make assumptions about the veracity of her statements. Facility staff would express concern and empathy and identify one person trained to gently collect essential information about alleged abuse. That employee would speak with Janet privately and respectfully and avoid pressuring her for details. The facility needs only that amount of information necessary to support the resident, file mandatory reports, preserve evidence, and protect all residents and staff from potential harm. Open-ended questions would be used to collect the minimum information needed. Janet would be informed of the facility’s legal duty to make abuse reports and assured that her confidentiality would be protected to the extent possible.
2. The facility’s long-term care ombudsman would be notified and would advocate on behalf of Janet to insure the protection of her rights. Janet would

be offered following: May we call a loved or trusted person for you? Would you like to be examined by a doctor or nurse with special forensic training? We can locate a specialist and arrange transportation for you. Would you like to speak with a police officer or a sexual assault counselor? What can we do to make you feel safer at this time? Janet would be offered a caring staff person whom she trusted to wait with her until investigators arrived and to accompany her to any other locations if that is what she wanted.

3. The facility would immediately make legally required abuse reports triggering investigations while evidence and memories were fresh. Reports would be filed in a factual and objective manner. The facility would assure that the location of the alleged attack was kept clear and untouched pending police investigation and that the suspect-resident was not interviewed but kept separate from other residents. Janet would be informed of her right to be examined by a specialist and asked to refrain from changing clothes or bathing until after examination.
4. Law enforcement would commence immediate collection of evidence and conduct an initial limited scope interview with Janet to determine the nature of the incident and the identity of the alleged perpetrator. The police officer and the APS worker would commence “victim-centered” investigations by speaking first with Janet. A coordinated investigation by both agencies could minimize the number of times that she was questioned. The officer and the APS worker would offer Janet transportation out of the facility for independent medical treatment, preventive care, and with Janet’s consent, examination by an objective and trained forensic specialist.
5. Janet would be offered assistance from an advocate from a sexual assault

program to explain investigative steps, support her through the forensic examination, accompany her to interviews, and help her through any subsequent criminal proceedings.

6. If Janet elected to see a Sexual Assault Nurse Examiner (SANE), that person would interview her in a sensitive manner and explain possible examination procedures, including the sexual assault evidence-collection kit. Janet would be supported in making an informed decision regarding submitting to evidence-collection steps, including an examination of the breast that had been grabbed and pinched and possibly swabbing the area for forensic evidence. The SANE would ask Janet if other parts of her body were touched or harmed, if she was in pain, and if she had other concerns about her health or safety. Janet would be given the opportunity to accept or refuse any part of the examination and evidence collection procedure. The specialist would carefully and factually document results from the interview and the examination.
7. If Janet disclosed to the APS worker that she was abused in the facility, that worker would ask Janet if she felt safe remaining there. If not, immediate effort would go into identifying an appropriate and safe location for Janet to stay until permanent housing could be arranged. In some states, law enforcement would obtain an emergency protective order to protect Janet from the alleged abuser and to stop contact with her. The court could also have ordered the alleged abuser to move out of the facility while the order was in effect if Janet chose to remain there.
8. If the accused resident was not removed from the facility by law enforcement, necessary evaluation procedures would occur to determine if he posed a

danger to other residents due to cognitive impairment, inability to self-control, or other factors. Plans would be made to reduce the danger he posed, perhaps by transferring the resident to a location with increased supervision.

9. Thorough investigations by the agencies responsible would occur that considered Janet's statements to the investigating worker and to the aide to whom Janet disclosed at 3 PM on the day of the incident, the powerful behavioral evidence (Janet's marked spending of days in her room, changes in patterns of eating, sleeping, socializing, and forensic examination results).
10. Being believed and supported, relocated to a safe setting, and receiving sexual assault counseling might help Janet to recover from this victimization and slowly resume her normal patterns and behaviors. A supportive counselor could slowly build trust with Janet and assess her psychosocial condition. This might identify the depression and reveal Janet's other recent traumas (widowhood, amputation, loss of mobility, loss of independent life style). Janet might elect to discuss the early traumatic memories that intruded upon her following the facility assault. The counselor could help Janet access medical evaluation of the need for medication for depression and Acute Stress Disorder, and other interventions such as a widow's support group, a support group for persons with recent amputations, or trauma-focused psychotherapy. Many costs for emergency and follow-up care could be paid through crime compensation programs.
11. A comprehensive, timely, and victim-centered police investigation, along with forensic evidence, might have resulted in arrest of the perpetrator and effective criminal justice response.
12. Had prosecution occurred, the prosecuting attorney would have met with



Janet to ascertain her perspective on the work with the victim-witness assistance program advocate and others to assure that Janet had transportation to court, wait time was minimized, and Janet had a safe and comfortable place to wait before testifying and during court recesses. The attorney and advocate would assure that victim-centered accommodations were made in light of Janet's advanced age, disability, and wheelchair use. The Victim Witness Advocate and Sexual Assault Counselor would support Janet in providing testimony, getting regular updates on the case's progress and all aspects of the criminal process. If the offender was convicted, Janet would have the opportunity to address the court and make a victim impact statement. In some jurisdictions, this would include her perspective on the appropriate sentence.

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## Summary

The late **life polyvictimization** project revealed significant evidence of the highly traumatizing nature of multi-faceted elder abuse. Chronic traumas, multiple traumas over the lifespan, and historical traumas may all intersect and compound one another in the **lives** of older polyvictims. Trauma is experienced subjectively, and individual factors influence how an older victim will be affected. Despite individual differences, trauma has a profoundly negative impact on physical and mental health. Victim-centered, trauma-informed care prioritizes the older victim's need for safety, respect, and acceptance, maximizes victim choice and control, and applies the empowerment model in which victim strengths are validated and serve as the foundation for recovery from polyabuse. Professionals across disciplines who respond to alleged and confirmed cases of late **life polyvictimization** can

apply trauma-informed and victim-centered principles in responding to victims and efforts to hold perpetrators accountable while preventing reoccurrence of abuse.

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## Disclosure statement

No potential conflict of interest was reported by the authors.

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