

# Exploring the Sexual Rights of Older Adults: Toward Healthy Sexuality and Freedom from Victimization in Later Life

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## Out of the Closet: Sexuality and Aging and Sexual Assault as a Form of Elder Abuse

Love, romance, and yes, sex can be a part of an adult's life at all ages. Many women and men experience their most passionate and meaningful relationships later in life. Anyone who has seen a couple in their 70s, 80s, or 90s in the throes of a new romance knows that the desire for physical and emotional intimacy is ageless – and beautiful at all ages.

Yet widely held stereotypes about the aging process and a lingering Puritanism keep many people from recognizing that older adults are sexually active or would like to be. When we mistakenly view older adults as asexual – one of the most extreme forms of ageism – we in fact deny part of their humanity, and for those of us who work with aging and elderly individuals, we fail to support their life choices.

Misconceptions about sexuality and aging and ageist beliefs have other serious consequences. Viewing older adults as asexual puts us at great risk of erroneously believing that they are somehow immune to sexual abuse or deadened to the pain of it simply because of their advanced age. Brutal, callous and dehumanizing crimes that spark outrage and revulsion when the victim is young are too often overlooked or minimized when the victim is an older person. Sexual violence against people in later life is still the least recognized form of elder abuse, and as a result, our responses to this widespread problem are under-developed and often ineffective.

At first glance, it seems strange to address healthy sexuality and sexual abuse together. Sexual expression is a natural and positive aspect of life; sexual abuse is a form of violence and a crime. Yet our failures to support healthy sexuality among older adults and also protect them from sexual abuse are indeed closely related. Both failings stem from the same ageist beliefs. To begin to overcome those beliefs and their consequences, The Harry and Jeanette Weinberg Center for Elder Abuse Prevention at The Hebrew Home at Riverdale hosted a day-long invitational colloquium that engaged a broad array of scholars and practitioners in frank discussion – about sexuality and aging and the fundamental human rights to sexual expression and freedom from victimization, as well as the “vexing matters of assessing capacity and promoting autonomy among older adults, which were threads binding the day's discussions,” according to Joy Solomon, Director and Managing Attorney of The Weinberg Center. This publication draws on the proceedings of the colloquium and is intended to serve as a primer on the subject for practitioners.

# Healthy Sexuality and Freedom from Victimization in Later Life

## Sexually active? Interested in sex? Among older adults, the answer often is, “Yes!”

**Myth:** Elderly people are asexual.

**Fact:** The majority of older adults are sexually active.

One of many myths associated with aging is that elderly people are asexual. Nothing could be further from the truth. Although sexual expression is not important to all older adults – just as interest in sex varies among younger people as well – research shows that the majority of older adults are sexually active, and many of those who aren’t would be if they could find a willing and able partner.

The National Social Life, Health and Aging Project interviewed a representative sample of approximately 3,000 adults ranging in age from 57 to 85 about their sexual practices. Some of the results are surprising. Among the oldest individuals surveyed, who were aged 75-85, more than half (54%) reported having sex 2-3 times a month, and nearly a

quarter (23%) reported having sex at least once a week. In addition, roughly a third reported engaging in oral sex. And across ages, about half of the men surveyed and a quarter of women reported masturbating – rates that are consistent for individuals with and without an intimate partner.

*Findings from a national survey of older adults suggest that roughly half of individuals aged 75-85 have sex 2-3 times a month and nearly a quarter have sex at least once a week.*

Not surprisingly, the likelihood of being sexually active was highly correlated with physical health: individuals with significant health problems were less likely to be sexually active. Equally important, the lack of an available, willing and able partner was one of the most common reasons older adults, particularly the women surveyed, were not sexually active.

As one physician noted, “loneliness and isolation, not erectile dysfunction,” drives much of the sexual abstinence among older adults.

## Healthy Sexuality – The Physician’s Role

Dr. Mark Lachs, Director of Geriatrics for the New York Presbyterian Health Care System and a practicing physician, routinely asks his patients about their sexual health, believing that “sex is a pleasure that should continue as long as possible, if that’s what people want.” “In the course of asking, I believe I’m educating people that it’s okay to talk about sex.” Dr. Lachs supports healthy sexuality by helping people address problems that decrease sexual pleasure or prevent sex and by promoting safe sex practices – “I encourage condom use if it’s not a monogamous relationship. It’s right up there with the flu vaccine in my opinion.”

The response from his patients has been overwhelmingly positive. “You have this sense that people are going to be

frightened when you raise these issues,” Dr. Lachs says, “but when you do it in the light of day, the responses are more like, ‘Wow, this person thinks I’m a human being who is actually sexually active.’”

Dr. Lachs, who also directs the New York City Elder Abuse Center, is alert to signs of sexual abuse among his patients. “Marriages that survive late into life actually have the highest degrees of marital satisfaction, but ... sexual abuse absolutely occurs.” Sometimes a healthy relationship turns abusive when an older spouse becomes hypersexual as a result of dementia. There is also evidence, according to Dr. Lachs, that the most common context for rape in older people, in or out of the nursing home, is not in the

community, but in nursing homes by hyper-sexual residents, not staff.<sup>1</sup>

Unfortunately, most doctors are not asking their older patients about their sexual health. Only 38 percent of men and a mere 22 percent of women surveyed as part of the National Social Life, Health and Aging Project reported discussing sex with a physician since turning age 50. Professional training for doctors and medical students should include information about sexuality and aging so that they are prepared to discuss these issues with their older patients. Another way to ensure that physicians raise sexuality-related health concerns is to include such questions in the assessment forms of electronic medical records.

## John and Jane

In his late 80s John was admitted to a residential care facility and diagnosed with moderate to advanced dementia. He had been living at home, where his wife was his sole caregiver, until his daily outbursts of anger became too difficult for her to manage. Initially, John's family was very involved in his life at the facility, but their visits became less frequent and

meaningful as his Alzheimer's progressed and he no longer recognized his wife.

One day John met Jane. Jane had entered the facility at age 74, with a history of mental illness and a diagnosis of primary degenerative dementia, but she was alert, ambulatory, verbal and had some awareness of her history and life story. Their relationship began spontane-

ously and progressed from friendship to intimacy. The two were constantly together, and their love for one another was obvious to staff and anyone else who encountered the couple. While Jane's daughter was thrilled, John's wife was not. Despite the staff's efforts to explain that John was making choices based on what he wanted and was extremely happy, the wife demanded that staff separate the couple.

## Navigating in Gray Areas: Assessing Capacity and Consent

**Myth:** An older adult with diminished mental capacity is incapable of actually choosing to form an intimate relationship and engage in sex.

**Fact:** Cognitive impairments don't necessarily preclude a person from recognizing their desire for intimacy and pursuing a meaningful relationship.

As individuals age, and especially if their mental capacity diminishes, whose choice is it how they live their lives? This difficult question obviously involves decisions about a person's housing and medical care – familiar terrain – and it also relates to life choices about intimate relationships and sexuality. In the view of scholar M.T. Connolly, a 2011 MacArthur Foundation "Genius" Award recipient, "We're trying constantly to balance dangerous self-determination on the one hand and unwanted safety on the other."

At The Hebrew Home at Riverdale, the stated policy is to uphold the sexual rights and present-day life choices of older adults. The Hebrew Home's progressive policy on sexuality is unusual; most residential care facilities lack any policy at all. According to Robin Dessel, who directs Memory Care Services and is a sexual rights educator at The Hebrew Home, the policy is crucial because "the voices of older adults often get lost" when relatives, especially those who are surrogates or legal guardians, have their own strong opinions about what's right or wrong.<sup>2</sup>

A clear policy affirming an older adult's right to sexual expression provides a solid foundation for navigating situations that are truly difficult to assess. Can a person with advanced dementia and clearly impaired judgment consent to sex? What are the signs of consent in this context? Does hypersexuality, which sometimes

accompanies dementia, make it impossible for a person to engage in a sexual relationship that is free of coercion and abuse?

*Someone who is incapable of making complex medical decisions might still be able to choose an intimate partner, be engaged in a meaningful relationship, and evidence their choices.*

According to Jean Callahan, Director of the Brookdale Center for Healthy Aging & Longevity, cognitive capacity exists along a continuum – with decision-making ability varying widely – and this capacity may gradually decline over time. "There is no bright line distinguishing capacity from lack of capacity," she says. It is important to remember that each choice and decision a person makes in life does not require the same level of cognitive ability. Someone who is incapable of making complex medical decisions might still be able to choose an intimate partner, be engaged in a meaningful relationship, and evidence their choices. Even nonverbal individuals display cues that indicate whether they are happy or hurt.

Issues of autonomy and consent also come into play when elder care professionals suspect sexual abuse. Should nursing home staff immediately separate residents if there's any sign of abuse? Should an emergency room doctor or sexual abuse counselor allow an elderly woman to return home to an apparently abusive spouse? Does the answer differ if the woman is mentally impaired or appears to be suffering from post-traumatic stress disorder? State laws sometime dictate responses, but in many situations the answer is neither proscribed nor obvious. Advocates for older adults stress that age alone should not be the determining factor. Equally important, communities need to develop sexual abuse services and a range of options that truly serve a geriatric population.

# Healthy Sexuality and Freedom from Victimization in Later Life

## Assessing Capacity

When determining an individual's capacity to consent to sexual relations, practitioners should consider: knowledge, cognitive ability, and voluntariness. Having knowledge means understanding the potential risks of sexual activity, appropriate times and places, and a potential partner's desire to participate in sex. Cognitive ability involves being able to make choices that are consistent with an individual's wishes and values. Voluntariness means that a person's decision isn't based on coercion, unfair persuasion or inducements.

## Recognizing Sexual Abuse

**Myth:** Older adults are unlikely to be victims of sexual abuse.

**Fact:** Advanced age does not protect individuals from sexual assault. In fact, evidence suggests that elderly people are more at risk of sexual abuse – from caretakers at home, in institutional settings, and from intimate partners.

Although older adults make up only five percent of people who show up in hospital emergency rooms and sexual assault centers

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seeking help, there are good reasons to believe that the number of victims is much larger than this statistic suggests.<sup>3</sup> Many older victims, maybe even most, either do not or cannot report sexual abuse when it happens to them. Equally true, when an older adult presents signs of abuse those signs are often misunderstood or ignored. Even when victims come forward with accounts of sexual abuse, they're frequently disbelieved – thought to be mentally ill, caught up in fantasy or seeking attention. A recent statewide study in New York revealed that documented cases of all forms of elder abuse are just the "tip of the iceberg."<sup>4</sup>

Our blinders and biases form significant barriers to understanding the size and nature of the problem, as well as to forging effective responses. A few things are clear, however: advanced age does not protect individuals from sexual assault. There are documented cases involving victims as old as 101. While ageism and myths about sexual violence as a crime of passion focus attention on young victims, older adults are often more at risk because frailty, physical impairments, dementia and isolation increase a person's risk of being sexually abused.

An accumulation of cases shows that the sexual abuse of older

adults takes various forms, occurs in a range of environments, and is often accompanied by other forms of abuse; that elderly men as well as women can be victims; and that perpetrators are a more varied group than many people might suspect:

- Following a whirlwind romance, a widow in her late 60s married a charming man she met at her senior center. Then everything changed. He became controlling and demanded sex, often raping her vaginally and orally several times a day.
- A male attendant in a residential facility raped a profoundly disabled 65-year-old man with an object. The victim suffered tears in his rectum so extensive that surgery was required to repair the damage.
- An older woman with severe dementia was assaulted multiple times by a hypersexual male resident in the nursing home where they both resided.
- A woman in her 90s who lived with her grandson and his wife was the victim of emotional abuse and financial exploitation, and finally a severe sexual assault by her grandson that left her bleeding and battered.

Without proper training, medical professionals, social workers, elder care professionals and domestic violence advocates will overlook or dismiss even obvious signs of sexual abuse if the victim is an older adult. When the recently remarried woman mentioned above, for example, confided in her primary care physician that her husband was "hurting her sexually," the doctor asked no questions and just gave the woman some vaginal cream. Her husband continued to rape her until she found a moment alone with the director of her senior center, pulled back her shirt to reveal bruises and said, "Please help me. He hurts me."

## *Sexual Abuse: Forms, Symptoms, and Injuries*

**F**orms. Sexual violence against older adults takes many forms and ranges from vaginal, oral and anal rape to inappropriate touching; and from painful acts that are not part of a prescribed nursing care plan or necessary for health and hygiene (e.g. cleansing inner and outer vaginal areas with alcohol wipes or inserting objects into the rectum) to taking sexually explicit photographs.

**Signs and symptoms.** Victims of sexual violence often experience acute trauma following an assault: increased anxiety and agitation, sleep disturbances, incontinence, crying spells, withdrawal and depression, decreased enjoyment in daily activities, and sudden attempts to leave a long-term care facility. A growing body of research shows that victims with advanced dementia and memory loss can experience post-traumatic stress disorder in the wake of sexual abuse.

**Physical injuries.** The most common physical injuries are to the genitals, anus and throat – although vaginal injuries can be difficult to detect or be absent in many post-menopausal victims; bruising on breasts, buttocks, thighs and neck; imprint injuries on other areas of the body; bite marks; and sexually transmitted diseases.

## **Case Study:**

### **Learning from an Ineffective Response to Sexual Abuse**

**The sexual assault.** A 76-year-old woman, widowed with no children, was sexually assaulted by a male resident in the long-term care facility where they both resided. It happened one morning, just before breakfast. At 7:15 am she was the first person in the dining room. A few minutes later a male resident entered the room, walked up to the woman in her wheelchair, put his hand under her shirt and said, “I want to play with your breast.” He then pinched her breast in a way that she later described as very painful. She was so shocked she couldn’t speak, let alone call out for help, but that afternoon when a Certified Nursing Assistant whom she liked and trusted came on duty, the woman told her what had happened.

**The response and its consequences.** To her credit, the nurse believed the woman and immediately reported the incident to her supervisor. The facility then commenced their own internal “investigation,” which involved staff members talking with the woman and separately with the alleged perpetrator who denied everything and later called his son and threatened to sue the facility. Although the facility reported the incident to Adult Protective Services (APS) as well as law enforcement as required by law in that state, senior staff had already concluded that the incident did not happen as the woman described, and perhaps didn’t happen at all, and that was

what they told APS and police.

APS staff did interview the woman and found her account to be compelling but were discouraged from interviewing the alleged perpetrator and never did, and in the end found the incident to be “unsubstantiated.” The investigating police officer collected no physical evidence and advised the woman not to press charges because the case amounted to little more than her word against his. Afraid to go to the dining room, the woman began eating her meals in her room. Facility records show that a psychiatric evaluation was completed and that the woman was diagnosed as having mild dementia. The records also include the following note: “Makes false allegations of sexual abuse. Monitor carefully.”

**What went wrong in this case?** The facility should have reported the incident immediately to external agencies as required under law, rather than drawing conclusions about what did or did not happen. The facility’s report should have triggered a full and formal investigation, including an interview with the alleged perpetrator. A specially trained nurse or physician should have examined the woman before she was bathed or had changed clothes to look for redness on her breast or other visible damage and to swab the area to perhaps recover skin cells from the man’s fingers. Then a week later, the woman should have been re-examined for signs of bruising. And the facility should have provided some protection to the woman as well as an opportunity to meet with a sexual assault counselor.

# Healthy Sexuality and Freedom from Victimization in Later Life

## Case Study: Portrait of an Effective Response to Sexual Abuse

**The victim's background.** After falling on the ice and fracturing her hip, Mrs. J. spent several months in a rehabilitation center but never regained the ability to walk and decided to move in with her daughter and son-in-law Charlie. Within a year, the daughter had a sudden heart attack and died. Charlie agreed to keep caring for Mrs. J, which at the time seemed like the best possible outcome since he was a certified nursing assistant.

**Discovering the abuse.** One morning, a nurse who made routine visits to monitor Mrs. J.'s physical condition and medication that found that her blood pressure was high, her pulse was racing, and she appeared upset. The nurse asked her, "What's going on? You seem not yourself, is something wrong?" Mrs. J told the nurse that she didn't like some things that Charlie was doing to her. "What don't you like? Tell me about it," the nurse responded. Although she was very embarrassed, Mrs. J. told the nurse that her son-in-law was taking photographs of her nude. With the nurse's encouragement, Mrs. J. explained that Charlie brought a camera and tripod into her room, undressed her, propped up her legs, and told her to smile pretty for the camera. "I don't like this. I don't think it's right," Mrs. J. said. "Well, I don't think that's right either," the nurse replied and asked Mrs. J. if she would like the behavior to be stopped. When Mrs. J. replied yes, the nurse said, "We need to make some phone calls and get some help for you."

**A rapid response.** Within a couple of hours, Adult Protective Services (APS) and law enforcement were involved. Armed with a court order, police search the house while Charlie was at work and found the tripod, camera, and several nude photographs of Mrs. J. Later that same day, the police arrested Charlie. In the course of the investigation, APS discovered that Charlie had also sexually assaulted Mrs. J. and used subtle forms of manipulation to keep her compliant and silent for some time. He was later convicted and sent to prison.

**What went right in this case?** The visiting nurse was attuned to the change in Mrs. J.'s physical condition and took the time to ask caring and open-ended questions to discover what was wrong. While this seems like a common-sense response, Mrs. J. was not experiencing a medical crisis and another visiting nurse with a roster of patients to see in the course of a day might have left without exploring the situation further. The nurse also reacted well to Mrs. J.'s disclosure that Charlie was photographing her naked: She validated Mrs. J.'s own sense that his behavior was wrong and then teamed up with her to take steps to stop the behavior. While the nurse might have said, "I'm going to report this," instead she said, "We need to make some phone calls and get some help for you." When calling APS and the police, the nurse put Mrs. J on the phone to describe the abuse, and she stayed with Mrs. J. as investigators and social workers interviewed her and began taking steps to protect Mrs. J. and arrest Charlie.

## Older Adults, Sexuality, and the Criminal Justice System

The first-ever multistate study of sexual assault in long-term care facilities revealed a problem that persists today: when the victim of sexual abuse is an older adult, the perpetrator is rarely held accountable. Researchers found and reviewed 124 cases involving victims 60 years or older in New Hampshire, Oregon, Texas, Tennessee and Wisconsin that came to the attention of Adult Protective Services (APS) over a six-month period in 2005.<sup>5</sup> The alleged perpetrators included roughly equal numbers of facility employees and other residents.

APS substantiated only a quarter of these cases (27%), a rate significantly lower than the 46 percent substantiation rate nationally for all cases of elder abuse. And cases involving staff as the alleged perpetrator were much less likely to be substantiated than cases in which another resident was accused of sexual abuse – 4 percent compared to 52 percent.

Perhaps most concerning, none of the alleged perpetrators were arrested. While the findings from this study are limited to a small number of sexual abuse cases that occurred in long-term care facilities, anecdotal reports and other evidence suggests that sexual assaults committed against older adults in their homes and elsewhere in the community are also unlikely to be prosecuted. Law enforcement agencies rarely pursue even egregious cases of sexual abuse involving older victims. And when police and prosecutors do get involved, they sometimes pressure victims to testify against abusive relatives when it's not in the victim's best interests and when it might be possible to build a convincing criminal case without the victim's active participation. These failings are exacerbated by the fact that sexual abuse committed in the community is less likely to be reported to law enforcement.

## A Delicate Balance: Privacy, Autonomy, and the Duty to Protect

Many states have laws requiring professionals who work with or encounter older adults to report any indication of abuse to designated authorities – typically Adult Protective Services (APS), law enforcement, and/or the Department of Health if the alleged victim lives in nursing home or other state licensed facility. The purpose of these laws is to protect elderly individuals who may not be able to seek help on their own. At the same time, it's important to involve older victims in the reporting process as much as possible, within the limits of any inability to comprehend the situation and participate in decision-making.

In states that lack mandatory reporting laws, signs of abuse can still trigger a report to law enforcement and perhaps other agencies. But in these states, there may be confidentiality laws that require obtaining the potential victim's consent before making a report. Determining whether or not an elderly person has the capacity to understand the gravity of his or her circumstances and make a reasoned decision to give or withhold consent can be difficult.

Elder care professionals must know the laws in their states and develop skilled interventions. Should a victim be allowed to remain in an abusive home or placed in a nursing home against her will, for example? The answer probably depends on the nature of the abuse and the possibility of stopping the abuse without removing the victim from his or her home. The process of responding to abuse often involves balancing an individual's rights to privacy and autonomy with the duty and desire to protect the person from subsequent abuse – and in the best cases, finding solutions that really work for individual victims.

## What You Can Do

**Seek training.** All professionals who work with older adults need to understand healthy sexuality and aging and also know the warning signs of sexual abuse and be prepared to respond. As Holly Ramsey-Klawnsnik, who has written extensively on the subject of sexual assault, remarked during the colloquium, “We all have an obligation to learn the facts and be prepared to respond compassionately and appropriately when a possible case of abuse comes to our attention.”

**Support healthy sexuality.** Within the parameters of your professional role, find appropriate ways to support healthy sexuality among your clients. This requires asking older adults about their sexual history and current practices as a part of intake and assessment procedures and during other routine interactions, especially if you are concerned that an individual may be involved in an unfulfilling or potentially abusive intimate relationship.

**Respond immediately** and appropriately to signs of sexual abuse. If you suspect that someone under your care is a victim of sexual abuse, your response should conform to these simple guidelines:

- Ask caring, open-ended questions: What's going on? How are you doing? Are you upset about something? Are you having any problems I can help you with? Even individuals with significantly diminished cognitive abilities, including those who cannot speak, can bear witness to abuses they have experienced.
- Validate what the person tells you about whatever he or she has experienced. It's a myth that elderly victims cannot be trusted to provide reliable accounts of sexual abuse.
- Team up with the person to identify and take actions that meet his or her needs for protection, medical care and counseling.
- Report the allegations of abuse immediately, following your agency's policies and the relevant laws in your state. Immediate reporting is essential to protecting individuals from subsequent abuse and to getting the appropriate medical care and counseling, and also to gathering the evidence necessary to hold perpetrators accountable.
- Collaborate with others. Protecting older adults from sexual abuse requires multidisciplinary relationships and collaboration among the many different agencies and systems that provide care and services for older people. The NYC Elder Abuse Center has developed a team-based approach in which professionals working in medicine, psychiatry, social work, law, finance and other relevant areas collectively assess, coordinate and leverage their interdisciplinary knowledge and practices to effectively respond to complex elder abuse cases. “Adapting this model for other communities will help to improve the safety, health and well being of older victims,” says Risa Breckman, Deputy Director of the Center.

## Colloquium Presenters and Facilitators

On May 6, 2011, The Harry and Jeanette Weinberg Center for Elder Abuse Prevention at The Hebrew Home at Riverdale hosted an invitational colloquium, “Exploring the Sexual Rights of Older Adults: Toward Healthy Sexuality and Freedom from Victimization in Later Life.” Co-sponsored by the Brookdale Center for Healthy Aging & Longevity at the City University of New York and the NYC Elder Abuse Center, the colloquium drew participants from several fields – elder abuse, domestic violence, criminal justice, medicine and social science research – and involved journalists and professionals in the field of philanthropy. The colloquium featured presentations by the following professionals.

**Valerie Abel, PsyD** – Clinical Psychologist/Neuropsychologist, VA New York Harbor Healthcare System

**Risa Breckman, LCSW** – Director, Social Work Programs and Education, Weill Cornell Medical College, Division of Geriatrics and Gerontology, and Deputy Director, NYC Elder Abuse Center

**Jean Callahan, Esq., MSW** – Director, Brookdale Center for Healthy Aging & Longevity

**Marie-Therese Connolly, Senior Scholar** – Woodrow Wilson International Center for Scholars and Director, Life Long Justice, 2011 MacArthur Foundation “Genius” Award

**Robin Dessel, LMSW** – Director, Memory Care Services and Sexual Rights Educator, The Hebrew Home at Riverdale

**Detective Lieutenant Eric W. Fischer** – Commanding Officer, White Plains Police Department-Detectives

**Cindy J. Kanusher, Esq.** – Assistant Director, The Pace Women’s Justice Center

**Deborah Holt-Knight** – Executive Director of Operations, NYC Adult Protective Services

**Mark Lachs, MD, MPH** – Irene F. and I. Roy Psaty Distinguished Professor of Medicine at Weill Medical College of Cornell University, Director of Geriatrics for the New York Presbyterian Health Care System, and Director of the New York City Elder Abuse Center

**Veronica LoFaso, MS, MD** – Associate Professor of Clinical Medicine, Weill Cornell Medical College, Wright Center on Aging

**Dianna Mejias, Esq.** – Special Victims Bureau, Queens County District Attorney’s Office

**Holly Ramsey-Klawnsnik, PhD** – Klawnsnik & Klawnsnik Associates

**Robin Roberts, LMSW** – Multi-Disciplinary Team Coordinator, NYC Elder Abuse Center

**Joy Solomon, Esq.** – Director and Managing Attorney, The Harry & Jeanette Weinberg Center for Elder Abuse Prevention at The Hebrew Home at Riverdale

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<sup>1</sup> Resident-to-resident elder mistreatment (R-REM) has become increasingly evident in nursing homes, raising the need to train staff how to recognize and respond appropriately when residents with dementia or other mental health problems become physically, sexually or otherwise aggressive. New York Presbyterian Hospital / Weill Cornell Medical Center and The Hebrew Home at Riverdale’s Research Division are currently engaged in a joint research and dissemination project on R-REM.

<sup>2</sup>Typically, surrogates do not have a legal right to make decisions that affect an elderly person’s sexual activity and relationships. While legal guardians have no explicit right in this area, they may conclude that sexual activity or an intimate relationship pose dangers to the individual and petition a judge for permission to move the person to another facility.

<sup>3</sup> The National Center on Elder Abuse (2007) defines sexual abuse as “non-consenting sexual contact of any kind,” including unwanted touching, sexual assault (e.g. rape, sodomy, coerced nudity), sexually explicit photographing, and sexual contact with any person incapable of giving consent.

<sup>4</sup>Under the Radar: New York State Elder Abuse Prevention Study, Self-Reported Prevalence and Documented Case Surveys, Final Report, prepared by Lifespan of Greater Rochester, Inc., Weill Cornell Medical Center of Cornell University, and the New York City Department for the Aging, May 2011.

<sup>5</sup> Ramsey-Klawnsnik, H., Teaster, P.B., Mendiando, M.S., Marcum, J.L., & Abner, E.L. (2008). Sexual predators who target elders: Findings from the first national study of sexual abuse in care facilities. *Journal of Elder Abuse & Neglect*, 20, 353-376.

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