

Counseling Elderly Female
Victims of Rape

by

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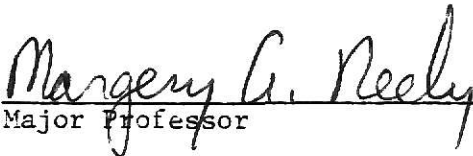
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Acknowledgments

For Norrine, who planted the seed,
For the women who nurtured it, and
For those it lives for.

**THIS BOOK
CONTAINS
NUMEROUS
PAGES WITH
MULTIPLE
PENCIL MARKS
THROUGHOUT
THE TEXT.**

**THIS IS THE
BEST IMAGE
AVAILABLE.**

Counseling Elderly Female Victims of Rape

According to Federal Bureau of Investigation national statistics, one out of every three women in the United States risks being the victim of a sexual assault during her lifetime (Longo & Goehenour, 1981). Rape is the fastest growing violent crime in this country. The Uniform Crime Reports for the United States-1974, published by the Federal Bureau of Investigation (U.S. Department of Justice, 1975), revealed that the number of reported rapes has increased 172.6 percent over the last seven years.

Unfortunately though, the past literature concerning this crime has not been representative of its true implications. Kemmer (1977) reviewed the literature published from 1965 to 1975 and found 348 entries: 121 dealt with legal implications, 118 with victim credibility, and only 30 with the victim's reaction and emotional adjustment. Hilberman (1976b) also noted that there was a striking absence of any significant literature about the victim, other than that relevant to strictly medicolegal concerns, although there were a number of articles dealing with the need to understand and rehabilitate the rapist. The assumption which permeated many articles was that the victim was not an innocent part to the rape: was she seductive, sexually active, drinking, out at night, did she know the assailant, did she reach orgasm? Since the publication of Against Our Will: Men, Women, and Rape (Brownmiller, 1975) there has been a shift in the emphasis of the literature.

Brownmiller's thoughtful, carefully researched historical and sociological analysis of the crime contends that any female may become a victim of rape, which is a crime of violence rather than passion. This is supported by the fact that rapists choose their victims without regard to physical appearance, age, race, or economic background. Unfortunately, there are still popular myths surrounding the crime of rape which have prevailed for

many decades, even centuries. Despite the vast technological, medical, and psychological advances of our age, rape has been a hidden topic for so long that many of these myths continue even though they have no factual basis.

Some of the more destructive myths follow.

1. The rapist is a sexually unfulfilled man carried away by a sudden uncontrollable urge.
2. Rapists are sick.
3. Rapists are strangers.
4. Rape occurs on the street, so as long as a woman stays home she is safe.
5. Most rapes involve black men raping white women.
6. Only women with "bad" reputations are raped.
7. Women are raped because they ask for it by dressing seductively, walking provocatively, etc.
8. Most victims have been in trouble with the law in the past.
9. Only women in the lower social classes get raped.
10. Women can't be raped unless they want to be.

A corollary of this might be that women enjoy rape.

(Regional Crisis Center, 1981, p. 20-22)

The most thorough study of the sociocultural aspects of rape was published by Amir in 1971, with many of his findings documented by others as well. His data encompassed all cases of rape listed by the police in 1958 and 1960 in the city of Philadelphia, and did not include incest or statutory rape. His total sample included 646 victims and 1292 offenders.

Three quarters of the rapes involved one or two assailants, with group rape the pattern in 27 percent. Of the total number of incidents, 71 percent were planned in advance, and only 16 percent could be considered impulsive.

This serves to challenge the "uncontrollable urge" theory of rape. Although mythology indicates that staying at home is safe, 56 percent of rapes occurred in the victim's residence, and the remainder were divided among automobiles, outside, and other indoor places. In only half of the cases was the rapist a stranger to the victim, while the remainder included casual acquaintances, neighbors, boyfriends, family friends, and relatives. The overwhelming majority of reported rapes were intraracial, with rapist and victim of the same race. Most statistics suggested a high proportion of black rape, but it is possible that black rapists were more likely to be reported and apprehended. Hursch's 1977 study in Denver concluded that victims were likely to be assaulted by an attacker from their own ethnic group, but the rapist's race was similiar to the at-large population, that is, 71 percent white, 15 percent black, 11 percent chicano.

In Amir's sample, physical force was present in 85 percent of cases, the remainder involving various degrees of nonphysical force, such as coercion, and intimidation with or without weapons. In one third of the cases in which physical force occurred, extreme brutality was evident. There was a higher frequency of both alcohol intake and prior criminal records with group rape assailants. The assault was usually planned, and was more brutal in terms of beatings and subjecting the victim to sexually humiliating acts in addition to rape.

Victim behavior was described by Amir as submissive in 55 percent, with some degree of resistance in the remainder. Two factors which were always considered by the rape victim were the actual rape and the possibility of other injury. At the time of the assault, the victim had to decide whether she had a greater fear of the rape or of other physical injury, and her actions reflected her decision. This presented something of a conflict in that resistance

increased the likelihood of violence toward her should she not escape.

Perhaps the most significant finding of Amir's study (1971) was that rape occurred in a context of violence rather than passion: "Rape is a deviant act, not because of the sexual act per se, but rather in the mode of the act, which implies aggression, whereby the sexual factor supplies the motive" (p. 150). While mythology notes that most rapists are sexual perverts who hide in bushes and hate female authority figures, Amir suggested that rapists are a danger to the community not because they are compulsive sex fiends, but because they are violent and aggressive. They often appeared psychologically "normal", but tended to have criminal records of offenses against the person, of which rape was just one, and they usually committed the offenses with brutality and violence.

Supporting this concept that rape is a crime of violence, studies have found that between 21 percent and 59 percent of assaults are accomplished with the use of weapons (Katz & Mazar, 1979), the most frequently used being a knife. The violation was in many cases accomplished not only by threat, but also by physical threats of further violence.

Often called "a way of debasing and degrading a woman" (Hursch, 1977, p. 6), and "the ultimate violation of the self" (Hilberman, 1976a, p. 436), rape knows no age limit. "Despite the fact that it has been observed that rape is a 'young man's crime', there is obviously no upper limit on the age of the victims of these crimes" (Hursch, 1977, p. 22). Though the median age range of sexual assault victims was found to be 15-24 years (Hursch, 1977; Krasner, Meyer, & Carrol, 1976; Woodling, Evans, & Bradbury, 1977), rape survivors ranged in age from four months to 94 years (Davis & Brody, 1979). What the rapist was looking for was not necessarily a beautiful woman, but a woman who was apparently vulnerable. Rapists often sought out vulnerable women by

preying on retarded girls, children, sleeping women, or old women (Woodling et al., 1977).

The rape of an elderly woman is particularly difficult to comprehend, perhaps because older people are likely to be more vulnerable to physical and emotional trauma and to its long-term negative effects. Since they are often dependent on others for care and protection, the rape of the elderly negates the myth that such an assault is primarily for sexual gratification. To make the elderly victim's situation and viewpoint clear two specific cases follow.

Case I

The attack occurred at 3 a.m. Sunday, July 26. Victim A, seventy-four years old, who had just been through major surgery for cancer, was sleeping in her living room, too weak to make it to the bedroom. She did not hear the assailant break in the back door.

When she woke up, the covers were over her head so she couldn't identify the intruder. He smothered her until she was in a semi-conscious state, and then beat her over the head. She tried not to lose consciousness because she felt her heart would stop if she did.

"His hand was so strong over my mouth, I could have gotten a little air to breathe had he only changed hands to hit me. By the time he raped me, I was too weak to struggle. It was really secondary because I just knew I was going to die" (Neff, 1982, p. E1).

Although Victim A had been badly beaten and was bleeding, there was no physical evidence that could link an assailant positively to the case. Since that morning, Victim A has taken sleeping pills to shut out the fear that someone would enter her home again and take control of her body (Neff, 1982).

Case II

Victim B was seventy-nine years old when she was raped. She lived in a building with a security entrance, so when a knock sounded at her apartment door she readily opened it with the belief that she was secure.

The man in his twenties who stood outside Victim B's door asked if she knew which end of the building contained apartment 306A, as he had grandparents there who had just moved in. He then asked if he might phone his grandmother for directions since he had her phone number. Victim B stepped back and invited him in.

Once the door closed, the intruder knocked Victim B against the wall with a slap. He grabbed her by the shoulders, dug his fingernails into her flesh, and demanded any money she had. She pointed to her purse on a table which contained only \$3.58. The intruder shook the terrified woman, slapped her, and threatened to kill her if she did not produce more. Shaking in terror she opened a drawer in which she had hidden \$40. He grabbed it saying, "Thought you'd trick me, didn't you, Grandma! Why you stupid old bitch." With that he grabbed her again, and as she tried to pull away, his grasp ripped her dress. He tore the rest of her garment away with one vicious wrench, threw her on the bed, and raped her.

When he had gone, Victim B realized that except for her corset and torn stockings she was lying there practically naked. Her head throbbed, body ached, and she became very, very sick.

From then on, the sound of her buzzer or a knock on her door froze all her senses. Days went by when she never emerged from her apartment. Nights were spent at her kitchen table dozing because she could not bear to lie down on that bed again. Finally, when her son came and found her looking

withered, he took her to her doctor. It was only then that she admitted what had happened. She never told the police (Hursch, 1977, p. 98-101).

Statement of the Problem

The true incidence of rape against any age group is not known at this time. For women of all ages, estimates of the percentage of rapes actually reported to the police ranged from 55 percent to as few as 5 percent, or one in twenty (Brownmiller, 1975; Hilberman, 1976b). Rape was one of the most underreported crimes because of fear and/or embarrassment on the part of the victim. All victims were terrorized, and 97 percent were threatened with bodily harm or death (Woodling et al, 1977). Others felt that they could not withstand the stresses of prosecution. Davis and Brody (1979) stated that the rate of nonreporting among elderly victims was especially high, not only because of fear of reprisal, embarrassment, and stigma, but because of perceived doubtful "credibility" of an older person's complaint. In addition, rape was lost to statistics if accompanied by the more serious crime of homicide, and an initial rape charge was also subject to plea bargaining to lesser offense.

Antunes, Cook, Cook, and Skogan (1977) concluded that rape was the least frequent personal crime against the elderly, being reported by only 0.1 percent of the total 375,000 sample population. But, officials at St. Luke's Medical Center rape crisis center for Kansas City, Missouri, identified elderly women as the second most likely candidates to face a rapist (Neff, 1982). Amir (1971) found that 3.6 percent of the reported assaults were directed toward elderly women. Of victims reporting to the Rape Crisis Center of Syracuse, New York, 5.2 percent were elderly and Fletcher (1977) noted that the average age of the rape victim was increasing.

The actual extent of rape was admitted as unknown, but Davis and Brody

(1979) estimated the rate of elderly rape victims could be as high as 19 or as low as 2 per 1,000 population. Further, statistics gathered on a group of convicted rapists in New Jersey correctional institution revealed that 12 percent of the rapes committed by these men were against elderly women.

Hursch (1977) concluded that elderly victims of rape were usually attacked in their homes. The assailant often broke in while the victim slept or came to her door and gained entrance on some pretext. Such rapes were often brutal and were accompanied by slapping, punching, and kicking the victim. Davis and Brody (1979) supported Hursch's conclusions by an analysis of 78 case histories of elderly women in New York and Philadelphia who had been raped. The case review indicated that the majority of elderly rape victims lived alone. Seventy-three percent of the elderly women were raped in their own homes, 50 percent during daylight hours, and 68 percent by a total stranger. In 65 percent of the cases, the rape was associated with a theft. It was not known whether the rapist entered primarily for rape or for theft. Many of the cases histories, however, revealed that what started out as a burglary escalated to rape when the burglar discovered the victim or became frustrated with her. Physical force was used by the assailant to assure compliance in 97 percent of the cases, and actual beating in 50 percent of the cases. Case studies revealed that in 43 percent of the cases, the elderly victim admitted the rapist into her own home. In 36 percent of the cases, the assailant gained access through an open window or unlocked door.

Consequently, being an elderly woman in the American society implied unique variables and characteristics that increased her vulnerability to rape. The impact of rape was aggravated by the diminished physical, social, and economic resources that often accompanied aging.

Groth (1978) concluded that the elderly victim may be more susceptible

to physical trauma from the assault. She may have fewer available friends or associates to turn to for support and comfort in time of stress. The social values of her generation may compound the psychological impact of the offense, and her sense of increasing helplessness and mortality may be activated by the rape. She may also lose possessions that symbolize important aspects of her life. The theft of money may create financial difficulties that limit her alternatives for coping with her trauma.

In this traumatic situation the elderly rape victim appears to require ~~unique~~ counseling considerations in order to initiate adjustment to her brutal victimization.

Purpose of the Report

The purpose of the report was to support the contention that for counseling of the elderly rape victim to be effective, issues different from those of typical rape victims must be addressed and that counseling needed to be tailored to the needs of the elderly victim. That is, there were unique considerations for the elderly rape victim that must be dealt with in the counseling relationship.

Specifically, the issues considered in this report were:

1. The variables that increased the elderly female's vulnerability to rape.
2. The impact of those variables on counseling the elderly victim of rape.
3. The factors which led to effective counseling of the elderly rape victim.

Definitions

Elderly Women

"Elderly" usually meant age 65 or over. In vulnerability to rape, the term included those in their early fifties and older. As stated by Davis and Brody (1979), the social and physical characteristics of middle-aged women often resembled those of their older counterparts. For example, many women between the ages of 50 and 65 are widowed, live alone, and face difficulties of economic and social adjustment following the death of a spouse. It is also during this period of life that physical changes began to appear, such as a limiting chronic illness or normal decrease in hearing and visual acuity, all of which contributed to increased vulnerability.

Rape

Rape is the act of carrying away by force according to the Merriam-Webster Dictionary, (Merriam, 1974). (While each state has its own definition of rape within its criminal statutes,) the legal definition of rape was carnal knowledge of a person by force and against that person's will (Evrard, 1971). Two elements constituted rape: 1) sexual intercourse and 2) commission of the act forcibly and without consent. The slightest penetration by the male organ constituted carnal knowledge; neither complete penetration nor emission is required. Force may be defined as the use of actual physical force to overcome the victim's resistance, or the use of threats which resulted in victim acquiescence because of fear of death or grave bodily harm (Hilberman, 1976b).

(Kansas law defined rape as the act of sexual intercourse committed by a man against a woman, not his wife, and without her consent when committed under any of the following circumstances:

1. When a woman's resistance is overcome by force or fear; or
2. When the woman is unconscious or physically powerless to resist; or

3. When a woman is incapable of giving her consent because of mental deficiency or disease, which condition was known by the man or was reasonably apparent to him; or
4. When the woman's resistance is prevented by the effect of any alcoholic liquor, narcotic, drug or other substance administered to the woman by the man or another for the purpose of preventing the woman's resistance, unless the woman voluntarily consumes or allows the administration of the substance with knowledge of its nature.

(Regional Crisis Center, 1981, p. 19)

The law denied the fact that women could be raped by their husbands, but a husband could be convicted of rape if he knowingly aided and abetted another in the rape of his wife (Woodling et al., 1977). Other offenses, such as oral and anal penetration, forced masturbation, and other forms of sexual violence were not legally rape, but were defined as lesser crimes in Kansas.

Review of the Literature

Davis and Brody (1979) noted that old age in the American society was often characterized by numerous variables which interacted to leave the individual more vulnerable to personal victimization and to reduced coping behaviors. The stresses of aging were abrupt and unexpected at times, such as death or illness of spouse, relatives, friends, and loss of job, income, or home. Others were gradual in onset and not immediately noticed, such as diminishing physical and mental capacities, chronic illness, and difficulty in maintaining productivity in major activities. All of these normal developmental conditions contributed to the vulnerability of elderly women to criminal victimization (Davis & Brody, 1979). Although Davis and Brody (1979) found there were many public examples of elderly women who were highly effective, the proportion who suffered from no physical, psychological, economic, or

social deprivations due to aging was small. The deprivations were cumulative and added up to heightened vulnerability. These deprivations not only limited the effectiveness of the elderly woman's behavior, but also the realization of this lessened effectiveness was fed back into the woman's self-concept. Thus, she both was more vulnerable and felt more vulnerable (Lawton, Nahemow, Yaffe, & Feldman, 1976). This increased vulnerability or "host factor" (Lawton et al., 1976) is what potentiated the risk of victimization, for the rapist actively sought out the vulnerable individual to assault (Woodling et al., 1977).

All elderly people were not passive, helpless and paralyzed by the fear of assault (Lawton et al., 1976). The majority of individuals demonstrated resiliency, even though many had been personally victimized. However, all who were potential victims were at greater psychological risk, and the perceived threat in the absence of effective coping behavior often was a critical factor in their ability to live satisfying lives (Lawton et al., 1976).

Variables Associated with Aging

The following physical, economic, environmental, historical-social, and psychological variables were often associated with aging and served to increase vulnerability to assault and magnify the impact of victimization.

Physical. Aging has been viewed as a period of decreasing physical strength and agility making resistance to attack less effective and more dangerous than for younger persons. There appeared to be age-related changes in vision, hearing, muscular strength and coordination and the speed with which reactions to external events could occur (Goldsmith & Goldsmith, 1976). The changes reduced the information-processing efficiency of the elderly woman, espe-

cially when she was required to react to a complex, unfamiliar, or threatening environmental situation (general intelligence, memory and judgment were not included among the skills that tended to become impaired by age alone). (Lawton et al., 1976). Hursch (1977) found that rape victims twenty years of age and older were less likely to resist an attack physically than were teenage women. A factor in this finding was that elderly women were less able to resist successfully due to biological changes connected with aging. Even relatively minor injuries inflicted during resistance could result in serious and perhaps permanent damage to the elderly victim.

Chronic conditions commonly found among elderly women were arthritis, hypertension, arteriosclerosis, heart and kidney disease (Davis & Brody, 1979). While a large percentage of elderly women had at least one chronic ailment, the majority functioned very well in spite of aging conditions (Davis & Brody, 1979). Unfortunately though, about 19 percent of the total elderly population were limited in mobility by illness. Five percent were housebound, six percent needed some assistance from another person to move about, and eight percent needed some mechanical aid (Brotman, 1976). Consequently, these individuals were more vulnerable to assault since the majority of rapes occurred in the residence of a victim who was vulnerable.

Sensory capacities were described as among the first to change with age. Specifically, the elderly woman might not hear approaching footsteps, or someone entering her home, or she might experience visual reduction in dimly lit areas. If an elderly rape victim did report the assault, the effect of aging on her perceptual facilities might hinder her assistance with regard to the investigation and apprehension of a suspect (Groth, 1978).

The need for and utilization of health services generally increased as women grew older (Davis & Brody, 1979). Even though elderly women saw

physicians more frequently than their younger counterparts, they were not necessarily receiving adequate health care. Difficulties in accessibility of services in urban areas, overcrowding, long waiting periods, and negative attitudes of those who administered the programs often served to hinder the woman in obtaining necessary health care (Davis & Brody, 1979). Thus, when raped, the elderly women may be hindered in seeking adequate medical aid.

Economical. Old age has also been described as a time of diminished income and fewer economic resources (Goldsmith & Goldsmith, 1976). Dependence on small fixed incomes from social security or other retirement payments and perhaps some limited savings often made old age a period of economic insecurity. The loss of a relatively few dollars-although it might be classified by authorities as a petty crime- could have a dramatic or tragic effect on the life of an elderly person who was without financial resources to replace money needed for food, medicine, rent, and other necessities (Goldsmith & Goldsmith, 1976). The loss of money could become especially traumatic when the theft was connected to rape.

As with other characteristics, the income and financial status of the elderly population varied substantially (Blake & Peterson, 1979). A small number of elderly people were well-to-do, but the greater part of the population found itself with lower income and assets than younger persons have. Although incomes rose for most persons from 1960 to 1975, the relative financial position of elderly compared to younger people improved only modestly. During that 15 year period, the older family's median income increased from 49.1 percent to 54.8 percent of the younger family's income (Brotman, 1977). Fear of criminal victimization was found to be greater for people at lower socioeconomic levels than for people at higher levels. Specifically,

Clemente and Kleiman (1976) concluded that of the elderly with incomes less than \$7,000 per year, 51 percent expressed fear of victimization. This compared to 43 percent of those with an annual income of more than \$7,000.

Preston (1976) stated that, "The poorest people in America today are women over 65, single and widowed. These 7½ million women have an average income of only \$1,888. One quarter of them have no assets at all" (p. 44). The result of this economic deprivation limited the ability of elderly women to purchase the goods and services that defended against victimization. Poor housing situations, lack of adequate and safe transportation, nutrition problems, and restricted social networks resulted partially from economic problems (Lawton et al., 1976). Harvey and Bahr (1974) found that the negative impact on life satisfaction sometimes attributed to widowhood is derived not from the widowhood status, but from economic status. The widowed appeared to have more negative attitudes than the married because they were much poorer than the married, and they appeared less affiliated for what was thought to be the same reason. That is, with lower income, lower social affiliation seemed to follow, and with that, decreased social support or help in the case of assault.

Environmental. Rape is primarily an inner city crime in areas where there is high concentration of multi-level apartment buildings . . ." (Hursch, 1977, p. 31). Increased vulnerability was also related to environmental factors associated with being elderly in America. It was often necessary for elderly persons to live in or near high crime areas of cities due to economic deprivation. Reasonably priced housing for single persons was often not available in more secure, suburban neighborhoods. Greater reliance on public transportation or on walking also increased exposure to assault (Goldsmith & Goldsmith, 1976).

National data indicated that the elderly, in general, were victimized less than younger people (U.S. Dept. of Justice, 1975). However, when elderly people in urban areas were considered, their rate of victimization by certain crimes (e.g., larceny, burglary, assault) often peaked to six and ten times the victimization rate of younger people who resided and worked in rural or low crime areas (Davis & Brody, 1979). Clemente and Kleiman (1976) found that although the rate of elderly women being attacked on the street was near only one per thousand population, 80 percent of such elderly women were afraid to leave their urban homes. It was also determined that residents of large cities tended to be more fearful of personal victimization than were elderly people in smaller towns and rural areas. Specifically, the percentages of the elderly showing fear decreased in a clear pattern as one moved from large cities to rural areas: 76 percent for large cities, 68 percent for medium size cities, 48 percent for suburbs, 43 percent for small towns, and 24 percent for rural locations (Clemente & Kleiman, 1976). In other words, while over three out of four elderly urban residents were afraid, only one in four of the rural elderly indicated fear.

Urban living not only produced fear, but the possibility of relocation produced traumatic fear; thus, a double-bind resulted. Many elderly women, often widowed, were reluctant to move away from the familiar neighborhood even if the moves were economically feasible. They remained in spite of the heavy population of potential assailants and the obvious risk to their well-being (Lawton, Kleban, & Carlson, 1973). Lawton and colleagues (1973) also concluded that declines in morale and even in functional health occurred among many elderly people who moved. In addition, if a person merely expected to move in 1969, morale and health tended to be poorer in 1972, regardless of whether they actually moved during the three years.

The elderly person living in the urban environment also confronted the problems of mobility and transportation. Public transportation was not only a means of obtaining necessary services, but was also used as activities in and of themselves, representing independence and sometimes even entertainment. Unfortunately, current modes of public transportation were difficult for many elderly people, particularly if steps and stairs were involved. Walking, the main means of transportation for many who did not have the financial means for other modes, was hazardous in lonely areas, at night, in crowds, and in crossing streets (Davis & Brody, 1979). These transportation problems increased the potential for victimization. They also served to increase the elderly person's awareness of her own limitations and vulnerabilities which caused an exaggerated sense of helplessness and fearfulness. One response to the fearful environment was to withdraw from community life in order to remain "secure" behind locked doors. Although this response may or may not have been a rational adaptation in the given situation, the result was a reduction of personal freedom and an assault on the quality of life available to the individual (Goldsmith & Goldsmith, 1976).

Aside from the negative aspects of an urban environment, there were positive aspects that could have been advantageous in planning a neighborhood security program. Congregate housing sites, such as apartment buildings, senior housing, and public housing were common forms of living units for elderly women. The nearness of neighbors and housing personnel could have been potential sources of support and protection (Davis & Brody, 1979). But, depending on the nature of the resident population and on the prevailing security conditions, the density within buildings could function negatively. In high-crime areas with age-integrated housing, for example, elderly women were often threatened, assaulted, robbed, and terrorized by younger neighbors

(Davis & Brody, 1979). However, residents in age-segregated housing were actually somewhat more fearful of crime in their neighborhood than were residents in age-integrated or mixed housing, and they were more isolated from social support systems (Antunes et al., 1977; Tedrick, 1980).

Historical-Social. In working with rape victims, Burgess and Holmstrom (1974b) found that the age of the victim seemed to influence how the victim coped with the crisis and what issues were of priority. Therefore, they concluded that understanding the historical and social perspective of the victim was important in order to better understand the meaning the rape has for the victim.

The common factor for all women of the same age range was the equal passage of time during which all had experienced similiar historical events and similar physical and social milestones in the lifecycle. As illustrated in Table 1, a "typical" 70-year-old woman experienced events from the "Roaring Twenties" to "Space Exploration" (Davis & Brody, 1979).

In addition to historical events, those in the same age group often shared attitudes, values and mores. While individual values were dictated by personal experiences, the norm of the time had a significant and long-lasting influence. For example, women who first learned of sexual matters during the late Victorian era were likely to be conservative in regard to sexual permissiveness or even discussions of sex. Often times the elderly woman was socialized to view men as protectors. But with rape the betrayal by the supposed protector who turned aggressor had a profound effect. Almost all rape victims said they trusted men less after the rape and that all men were suspect and potentially on trial (Notman & Nadelson, 1976). Hammond and Sink (1980) also stated that the elderly woman who was socialized with the Victorian concept believed that women should not have interest in any form of

Table 1. Historical and developmental milestones in
the life of a typical 70-year-old woman, 1977

Year	Age
1900 Horse and Buggy Days	
1905 Teddy Roosevelt President	
1910	0 Birth (1907)
1915 World War I Prohibition	6 Starts to school
1920 Womens Suffrage	12 Puberty
1925 Roaring Twenties	18 Employment Voting
1930 Lindbergh's Flight Depression	Marriage Parenthood
1935 Prohibition Repealed Equal Rights Amendment Introduced	
1940 Pearl Harbor World War II	30 Husband goes to war New directions in employment Peak productivity
1945 Atomic Bomb Television	40 Children leave home Menopause
1950 Korean War	
1955 Sputnik	50 Death of parents Grandparenthood
1960 Presidential Assassination Vietnam	Distant movement of children
1965 Lunar Landing	
1970	60
Presidential Resignation	65 Retirement Death of spouse, friends
1975 Exploration of Solar Planets	70 Great-Grandparenthood Frailty
1980	80+ Death
1985	

Source: Davis, L.J. & Brody, E.M., Rape and older women: A guide to prevention and protection. U.S. Department of Health, Education, and Welfare; Public Health Service; Alcohol Drug Abuse, and Mental Health Administration, Rockville, MD: National Institute of Mental Health, 1979 (p. 14).

sexual activity as they grow older. Consequently, the sexual aspect of rape was likely to be traumatic for the elderly victim. Many of Brody and Davis' (1979) elderly subjects found discussion of rape embarrassing. Eighty percent of the elderly women interviewed said they would be humiliated, devastated, ruined, or otherwise drastically affected if raped, and all feared severe physical injury. In addition, their embarrassment and hesitancy to discuss rape could contribute to estimates that rapes of elderly women were greatly underreported. This would particularly be the case if the elderly woman believed the mythology behind rape due to her socialization.

As illustrated in Table 1, different social roles were experienced and fulfilled throughout the lifespan. A major problem for elderly women is that most lived beyond their major roles as spouse and parents of dependent children. The majority experienced a crisis phase about her life role, with changes in her relationship to significant others and role loss (Hilberman, 1976b). Major roles were lost with age and with them the sense of self-esteem associated with a wide range of relationships and status. Notman and Nadelson (1976) wrote that for the elderly woman issues of her ability to have control and her concerns about independence were particularly important. The elderly woman often experienced self-devaluation, feelings of worthlessness, and shame since she was past her most sexually active period of life. This was due to the social misconceptions that with age came a diminished sexual role and ultimately that an older woman had less to lose by a rape than did a younger woman. These negative misconceptions served to seriously impede the elderly woman's ability to resolve the rape crisis (Hilberman, 1976b). Social stereotyping that the elderly woman was an unattractive, passive, complaining, asexual and useless creature also occurred due to major role losses. This negative social image was incorporated by some elderly women into their

own self-images with self-crippling results (Block, Davidson, Grambs, & Serock, 1978). Self-degeneration served to perpetuate the victim role of the elderly woman which increased the likelihood that a rapist would choose an elderly woman because he believed she was easy prey. Butler and Lewis (1977) termed this negative social misconception of the elderly "ageism". Ageism, a systematic stereotyping of and discrimination against the elderly, was used to point out that the elderly were parasitic, physically and intellectually incompetent and generally valueless (De Beauvoir, 1972). The notion that people ceased to be the same people by virtue of age not only placed an unjust burden on elderly individuals, but it also contributed directly and indirectly to their increased vulnerability to crime (Davis & Brody, 1979).

Another common belief in society was that most elderly women lived alone and, furthermore, had been abandoned by their children (Blake & Peterson, 1979). Such a belief suggested that most elderly women were alone both physically and socially and, therefore, were more vulnerable to victimization. While aloneness and loneliness were felt by some, only about one-third of all elderly women lived alone and one-third lived with a spouse or with a nonrelative (Blake & Peterson, 1979). Approximately 80 percent of elderly people had living children with somewhat smaller estimate of 65 percent for inner city urban dwellers (Cantor, 1975). This type of social support was of utmost importance to the victim of rape. Krasner and colleagues (1976) found that for the victim's positive adjustment to occur after rape, if the reactions of those close seemed removed, insensitive, and repelled, she would have trouble overcoming her anxieties and forming new close relationships. This conclusion was also supported by Burgess and Holmstrom (1974b) who stated that "The stronger the relationship between the victim and important people

in her life, the greater the chance that she will be supported through the crisis period by them and will need minimal counseling input" (p. 139). Elwell and Maltbie-Crannell (1981) suggested that major role loss, such as widowhood, represented a major loss of social support. But to buffer loneliness and grief associated with loss of spouse, social participation outside the family contact was an important source of adjustment to the crisis. Unfortunately, elderly women often were subject to the stress of social deprivation due to lack of financial means to seek out social affiliation, environmental limitations, or socialization restrictions. For example, Bernard (1976) speculated that during the nineteenth century much of the female's need for affiliation was met through her ties with other women, through sharing of experiences such as childbirth. During the twentieth century, female companionship was denigrated in favor of male attention, thus for the present day elderly woman, an important source of emotional support and social affiliation might have never been established.

Regardless of family or outside social support services, every community had a minority of isolated, lonely, and forgotten elderly women. Because of their lack of social roles or relationships they were clearly more vulnerable to victimization (Davis & Brody, 1979).

Psychological. "Old age is the period of life with the greatest number of profound crises, often occurring in multiples and with high frequency. The critical psychological events in this age group are the familiar human emotional reactions to death and grief diseases and disabilities. Depression and anxiety escalate, defensive behavior is seen, earlier personality components may reappear in exaggerated forms, and newly formed functional states are frequently noted. The conditions require psychotherapeutic efforts, indepth

as well as supportive" (Butler & Lewis, 1977, p.1). When general inattention to the mental health of older people, the specific diagnostic and methodological problems, and the meaning of mental health which complicated the effort to picture the status of the elderly population were considered, the evidence seemed to indicate that the mental health of the elderly population was worse than that of those who were younger (Blake & Peterson, 1979). Considering the multiple challenges to adaptation prevalent in elderly age groups, Blake and Peterson (1979) did not find it surprising that psychological problems were more frequent among the elderly. Specifically, they found the elderly people made up one-fourth of admissions to state and county mental hospitals. Population surveys also suggested that mental illness rates increased steadily with age. Elwell and Maltbie-Crannell (1981) postulated that stress was a factor in dissatisfaction with life, and with the developmental and situational stresses faced by elderly people--such as loss of employment, decreased income, loss of spouse, acquaintances, friends, and relatives, declining health, and increased health care costs--dissatisfaction and depression tended to follow. Weissman (1972) determined that depression was one of the leading symptoms in women who sought psychological treatment. Also, one of the most significant breakthroughs in female mental health was the growing acceptance of depression in elderly women as an emotional disturbance with social-psychological roots rather than being biologically linked to menopause (Wolleat, 1980).

The incidence of suicide in women peaked around the age of 50 (Wolleat, 1980). If all types of potentially self-destructive behavior were considered (e.g. overeating or undereating, smoking, delay in seeking medical treatment, drug abuse, and alcoholism) life-threatening behavior was a serious psychological problem among elderly women (Wolleat, 1980). Unfortunately, even

with increased stresses and psychological difficulties, elderly people did not receive their fair share of counseling, mental health, and social services. For example, only four percent of people seen in community mental health centers were elderly (Cohen, 1977). A survey of federally assisted centers found that elderly people made up 12 percent of catchment area populations for community mental health centers, yet only one center in ten saw as many elderly as was expected on the basis of their numbers in the catchment areas. One factor that created low representation was the reluctance of the elderly client. Most elderly people did not actively seek counseling and mental health services (Berkman, 1977). Often, during the formative years, individuals developed a basic value system, internalizing the values of the society. When the values of today's elderly were being formed, seeking counseling or therapy was viewed by society with disapproval in contrast to more recent times when obtaining such professional assistance was viewed more favorably. Elderly people may also hold the belief that they should be mature enough to handle their own problems without counseling; that they would be considered by others as less capable or independent if they engaged in counseling; and then, by accepting counseling assistance, they might be taking the initial step on the road to institutionalization (Ganikos, 1979). Along with the reluctance of the elderly to seek counseling there was what Kastenbaum (1964) termed the "reluctant therapist". The reluctant therapist devoted little attention to the psychological, social, and basic life-coping needs of the elderly. Mental health workers spent most of their energies on the young, attractive, verbal, intelligent, and successful person, a rather elite group that excluded the elderly person (Schofield, 1974). Counseling the elderly was also uncomfortable for the reluctant therapist because the helper was reminded of his or her own fears about the aging

process and death. Therefore if the elderly rape victim was unlikely to seek out psychological assistance from a professional helper she was likely to suffer emotional trauma alone. If she did seek help, she might not receive adequate assistance.

With increased life stresses came increased vulnerability and the fear associated with this vulnerability. Lawton et al. (1976) suggested that fear of criminal victimization was very high, notably among elderly women with low incomes. Data collected by Clemente and Kleiman (1976) strongly supported the assumption that the elderly were more afraid of crime than their younger counterparts. While 51 percent of elderly respondents said they were afraid, only 31 percent of younger respondents admitted fear. Women were also more likely to express fear than were men. Cohn (1979) determined that fear was related to lack of control and feelings of helplessness. People who belonged to community organizations to solve crime reported feeling less fear of crime and more control over crime than people who did not belong. People who engaged in many avoidance behaviors reported feeling more fear of crime and less control over crime than those who engaged in few avoidance behaviors. Elderly subjects reported feeling less control over crime than did younger subjects, and the elderly were more likely to engage in avoidance, passive behaviors than active behaviors against crime. Fear was a product of perceived threat and, in many cases, the fear was unwarranted when considered in relation to actual crime rates (Goldsmith & Goldsmith, 1976).

While overall actual victimization appeared to be relatively low, fear was pervasive among elderly women. Some women reacted to fear by taking appropriate protective measures in a high-risk situation while for others, fear itself "victimized" to a greater extent than did the incidence of actual crime. Some individuals were paralyzed by fear or placed themselves in "house arrest" where they were isolated from social contact. Pervasive fear

could have a devastating psychological effect on the elderly woman who already has experienced the special problems of growing old. Excessive fear could induce preoccupation to the point of obsession with protective behaviors and devices, and restriction of social affiliation (Davis & Brody, 1979).

Summary. The special vulnerabilities of the elderly woman to rape were as follows:

1. Normal physical capacities were diminished, thus restricting her ability to escape, defend herself, or identify the assailant. Limited visual and auditory acuity resulted in a threat being unrecognized. She might also suffer from a variety of physical or mental impairments which rendered her unable to use complicated precautions against victimization and made her virtually helpless if assaulted.

2. Economic deprivation limited the extent to which the elderly woman could purchase goods and services to protect her from victimization. The vulnerability of the elderly woman was increased further if she was dependent on walking and on public transportation.

3. Most elderly women in the urban environment did not live alone. In addition, most had some network of social support. There were many however, who were alone or who lived in poverty in run-down, high-crime areas. Social isolation had a direct effect on the elderly person's ability to control exposure to crime. The person living alone in a household was more vulnerable by being required to function alone outside her home. These single elderly women were most vulnerable to victimization and were frequently and repeatedly preyed upon by assailants who may have been their neighbors.

To the extent that the elderly woman possessed the characteristics of physical or mental impairment, poverty, aloneness, dependence on walking

and public transportation, poor housing conditions, routine predictable behaviors, and overt behaviors that demonstrated vulnerability, she was susceptible to rape.

Reactions to Rape

After rape, each victim reacted in unique as well as anticipated patterns. To understand the elderly victim's reaction to rape the typical victim's reaction was investigated.

Kilpatrick, Veronen, and Resick (1979) conducted a longitudinal study of the effects of rape on the victim's subsequent psychological functioning, and found that a rape experience had an immediate, profoundly disruptive effect on the mood state and other functioning of the victim. Rape produced extreme trauma, but at three and six month assessment periods, the victims appeared to have largely regained psychological equilibrium. However, there remained a core of distress that reflected focalized fear and anxiety which for many rape victims seemed inescapable.

A group of responses common to many rape victims was identified by Burgess and Holmstrom (1974b) which were labeled the rape trauma syndrome. The syndrome contained two stages which could overlap and were modified according to the unique response of each victim. The first, the acute stage, occurred immediately after an assault. Victims often appeared to be in shock and exhibited crisis reactions such as hysteria, inability to concentrate, confusion, nightmares, skeletal and muscle tension, and gastrointestinal and genitourinary irritability.² The second, the reorganization stage, was longer term and was best characterized as a stage of "picking up the pieces," of working through and integration. This took several months to many years and involved the victim getting beyond the crisis experience and restructuring her life. During this reorganization stage, various factors affected the

victim's coping behavior regarding the trauma (i.e., ego strength, social network support, and the way people treated them as victims). Emotional reactions to rape included fear, anxiety, guilt, self-blame, embarrassment, shame, revenge, and anger. Long-term effects of rape generally consisted of increased motor activity, especially through changing residence. There was also a strong need to get away from the physical environment in which the rape took place and a need to turn for support to family members not normally seen daily. Out of Burgess and Holmstrom's (1974b) sample, 73 of 92 women interviewed had some social network support to which they turned. Woodling et al. (1977) concluded that the single most important determinant of eventual emotional well-being of the victim was whether a suspect was identified and successfully prosecuted. Those victims of rape in which a suspect was not identified or successfully prosecuted had more phobic reactions, more sexual problems, and more interpersonal problems after the assault. (Most rape victims experienced an intense loneliness that was best reduced by physical acceptance, but many victims were unable to resume their usual sex style in the acute phase or for many months.) Data showed that most victims had sexual problems after the rape, and about two-thirds encountered serious interpersonal problems. Hilberman (1976b) discussed fairly predictable responses to the rape trauma. Among them were 1) disruption of normal patterns of adaptation with disturbances in eating and sleeping, diminished function, attention, and concentration span; 2) regression to a more helpless and dependent state in which support and nurturance were sought outside of the self; and 3) increased openness and accessibility to outside intervention, which presented unique opportunity to affect the long-term outcome of the crisis. Burgess and Holmstrom (1974b) concluded that the rape victim regressed according to her vulnerability. Such vulnerable positions were

portrayed from a history of emotional disturbances, poor access to a social supportive network, or financial or physical problems.

The elderly rape victim's reactions also varied but pervasive concerns appeared to be physical injury, fear of death, psychological devastation, long recovery, increased anxiety, financial problems, and loss of independence (Burgess & Holmstrom, 1974b). The concern about death was also documented by Capuzzi, Gossman, Whiston, and Surdam (1979) who stated that how and where death will occur and whether it would be a death with dignity was often a central concern of elderly women. The elderly victims interviewed by Burgess and Holmstrom (1974b) commented that they particularly feared to die in such an undignified way as during rape. Davis and Brody (1979) found that since there were varying life circumstances among different age groups, the impact of rape was likely to be different on women of various ages. A 70-year-old widow, for example, did not have to deal with the effect on her husband or with the threat of pregnancy. She might however have isolation or physical problems to contend with.

There were no published studies on the differential impact of rape on older women when compared with younger women; however, some evidence did suggest possible differences in effect. Davis and Brody (1979) found that there was a significantly higher severity of physical injury, especially to genital areas, among elderly women. In addition, rape counselors reported the "aggressive" rather than the "sexual" aspects of rape as the most psychologically traumatic for elderly women. The opposite was true for younger women, who seemed more traumatized by the sexual aspects. Some rape counselors held the view that many elderly women better tolerated stress (especially after a lifetime of experience in a high-crime, high-stress neighborhood) and therefore were less traumatized by rape (Davis & Brody, 1979). Others felt

that elderly women's reactions were initially strong, but later, after sympathetic supporters were gone, became depressed and fearful. Still others believed that elderly women were severely and permanently traumatized by the violent attack. Krasner et al. (1976) also concluded that elderly women were less concerned with sexual or domestic conflicts than with injury during rape.

Summary. In reactions to rape, younger women often worried about the support they might get from the people with whom they lived, while elderly women did not always have the support of anyone to get through the aftermath of rape. They were often alone and afraid that it would happen again. Once victimized, the elderly woman perceived that external factors, such as other people, fate, or chance, controlled her life; this was especially true in a crime such as rape. Perception of loss of control was likely to have a profound and permanent impact on the elderly woman (Davis & Brody, 1979).

Ultimately the impact of rape on an elderly woman must be examined in the context of the inherent character of the crime and the life situation of the elderly victim.

Counseling Process

Certain counseling orientations appeared appropriate for aiding female victims of rape. Crisis theory, developmental stage/coping theory and grief theory contributed to the helping relationship in concert. Some factors that affected the victim's response to rape included: a) the uniqueness of the assault, b) developmental stage of the victim, and c) the victim's characteristic coping behaviors (Doweiko, 1981). The individual's reaction to the rape crisis was dependent upon past stress and what success the woman had previously in solving stressful situations. Elwell and Maltbie-Crannell (1981) concluded that age itself was often a coping resource since age had a direct impact on the number and magnitude of stressors encountered in life. The elderly were

more likely to experience many types of stressors. These stressors included relocation, role loss, death of friends and relatives, and changes in health. All of these life events were not only stressful but, at times helped the individual develop coping behavior for future losses. Stress was often synonymous with crisis, for both initiated a turning point in the individual's life. (Rape was a stress situation which heightened the victim's sense of helplessness and intensified her conflict between dependence and independence (Hicks, 1980). Thus, if the professional helper were to understand the crisis which rape precipitated, knowledge of the three theoretical approaches was helpful (Bard & Ellison, 1974).

Crisis Theory Emphasis. Hicks (1980) defined crisis as "A point that occurs when a person faces a problem that cannot be solved by the methods she has utilized to solve previous problems. Therefore, tension mounts. A period of disorganization ensues and alternative methods of coping must be found" (p. 932). Burgess and Holmstrom (1974b) found that rape was essentially a traumatic crisis since the assault (a situational crisis) interacted with the developmental crisis, which was a stage in the lifecycle. According to Erickson (1950), the elderly adult was at a stage in life development where one gained a fuller perspective on a philosophy of life. This perspective implied emotional integration and a sense of wisdom in one's lifestyle. As previously stated, for elderly women, the rape as a sexual assault was not the primary concern. Elderly women were sensitive to the fear of death from the aggressive assault. They were also concerned for their family members and reactions to news of the assault. Fear of contracting a venereal disease was a concern, but serious physical trauma appeared to be the elderly victim's chief concern (Burgess & Homstrom, 1974b).

Thus, the rape took on a specific meaning to victims according to their

stage of development in the lifecycle. The counselor needed to look at the developmental point of the victim and historical and cultural context to understand what the attack meant to the victim at that age to be effective.

The counselor of rape victims had unique responsibilities that needed to be considered before the counseling relationship was initiated. Hilberman (1976b) gave responsibilities as:

1. Crisis intervention and long-term intervention: helping the victim and her family/friends deal with the emotional trauma of the rape.
2. Information: defining the medical and legal ramifications of rape, the implications and specifics of reporting, prosecuting, etc.
3. Referrals and follow-up: finding resources for medical needs, criminal justice information; follow-up with contact to assess emotional state, victim safety, and arrange gynecology follow-up.

For the elderly rape victim, responsibilities also included establishing routine counseling sessions at brief intervals, assessment of any of the victim's physical decrements and how counseling could be structured around them (home visits, hospital visits, sitting close and speaking especially clearly for the client with a visual and/or auditory loss, etc.), and taking an active and suggestive role in counseling. When these aspects were accounted for, counseling the elderly seemed especially effective (Smith, 1980).

Counselors also had the responsibility of assessing the victim's previous adjustment, including stress tolerance and adaptive resources. In addition, it was important to learn whom in her environment the victim saw as supportive and to attempt to involve those people if possible (Notman & Nadelson, 1976). If the victim could not count on receiving support from friends or family (often the elderly victim's situation) the counselor must prepare to a) give immediate support and technical information, and b) provide knowledgeable

long-term counseling (Heppner & Heppner, 1977).} Heppner and Heppner (1977) also developed three primary goals for the initial stages of counseling a rape victim. First, the counselor must establish a sound working relationship with the victim, one in which the counselor remained calm, supportive, and conveyed trust and understanding. In this trusting and supportive environment, the victim often began to feel comfortable enough to ask informational questions, which led to the (second) goal: providing practical information. The (final) goal of the initial counseling session was the exploration of the need for long-term counseling. It was noticed that counseling began from the time the victim was first seen since rape was a crisis situation requiring some intervention (Hicks, 1980). Also, Courtois (1979), and Doweiko (1981) both contended that although there was a general pattern to the adjustment process to rape, individual response patterns were extremely flexible, each victim was unique, and counseling should be tailored to the individual.} This was particularly true in the case of the elderly victim who confronted different issues from the younger victim.

\ Developmental Stage/Coping Theory Emphasis. Basic assumptions which underlied counseling for the younger rape victim were:

1. The rape represented a crisis in that the woman's style of life was disrupted.
2. The victim was regarded as a "normal" woman who functioned adequately prior to the assault.
3. The counseling was issue-oriented. Previous problems were not a priority for discussion. The goal was to return the woman to her previous level of functioning.
4. An active role in counseling was taken to initiate therapeutic contact.

(Burgess & Holmstrom, 1974a, p. 984)

Two of these assumptions were developmental stage specific and did not hold true when the victim was elderly. Specifically, the elderly victim was not "normal" since she was not the typical younger victim, and in being unique her victimization and functional issues were unique. Also, counseling of the elderly rape victim could not remain "issue-oriented" since her victimization was the culmination of other issues that needed to be dealt with, and to return her to her "prior level of functioning" would be returning her to victimization. However, with either the elderly or typical rape victim, it was important for her to regain a sense of control over her life, to re-achieve some sense of personal autonomy, and to understand her response to the assault (Courtois, 1979).

To help the rape victim regain control the counselor guided the victim through three phases during counseling. Burgess and Holmstrom (1974b) called these the introductory, working, and concluding phases, while Doweiko (1981) labeled them the acute reaction, outward adjustment, and the integration phases. During the acute reaction phase, the counselor encouraged the victim to talk about the assault. The victim was allowed to talk and to ventilate her feelings, with reassurance and validation of her responses. The counselor also took the responsibility to help the victim regain control by preparing her for subsequent medical, legal, and social events. In this first phase Burgess and Holmstrom (1976) assessed the coping behavior and strategies of the victim for two therapeutic measures. (First,) the assessment was used as a supportive measure, for while listening to the victim recount the assault the counselor could identify coping behavior and acknowledge this information to the victim. This in turn reaffirmed the victim's view that she was able to have some control in a highly stressful situation. (Secondly, the assessment of coping behaviors gave the counselor a reference point from which

counseling could begin. } Both therapeutic measures were appropriate for young as well as elderly victims of rape.

The second phase, outward adjustment, involved the victim beginning to use defense mechanisms of denial, rationalization, and suppression, and interest in seeking long-term counseling waned. During this phase the counselor helped the victim understand this temporary stage in the adjustment process and that there was another phase yet to come.) Heppner and Heppner (1977) also suggested emphasis on identifying the victim's fears, and reducing the individual's stress. (Common fears exhibited were fear of insanity (e.g. "I'm afraid I'm going crazy.") and fear of the rapist returning. Several cognitive-restructuring techniques were employed to alter fear-producing thoughts. These included thought stopping, thought substitution, self-reinforcement and the development of concrete defense plans.) Not only fear but also anger was investigated during this phase. } Little direct anger was demonstrated by rape victims. This phenomenon could originate from the assumptions that the American culture supported patterns of self-blame and that women were socially reinforced to suppress anger (Notman & Nadelson, 1976). During this stage, the counselor gave the victim license to become angry. At this phase the victim needed reassurance and understanding, not sympathy from the counselor. The victim was allowed to ventilate and to vocalize anger and fear. If this was not possible, these emotions were buried and did not surface for weeks, months, or years. Once the emotions came to the surface, the counselor could help the victim rebuild her sense of worth and make her realize she was again in control of her life (Hicks, 1980). This sense of control and worth was especially difficult to instill in some elderly women for several reasons, as Wolleat (1980) found while counseling elderly women. First, one of the primary deficits of the female

experience was in acquiring a sense of self or seeing oneself as a person with value; next, the elderly woman who achieved her identity primarily through the roles of wife and mother was threatened by current attacks made on traditional feminine roles.

The counselor helped this woman gain confidence in her ability to choose and to implement the roles she desired in older years. Many elderly women did not understand that they felt inferior because society expected them to feel that way (e.g., ageism and sexism) and many elderly women never took themselves, their ideas, and goals seriously; they were "programmed" by someone else. With massive changes in economic resources and physical capacities, many elderly women did not realize they were coping well with these factors, and many others were socialized to look to others for problem solving or decision-making strategies, and for the source of their goals and expectations. The counselor should use every opportunity to affirm the elderly victim's worth during the counseling relationship, and to be aware of these factors in helping the woman develop a positive self-image.

Finally, the integration phase often began when the victim became depressed and needed to talk. In most cases, depression was not a symptom of serious emotional disturbance, but rather was an attempt on the part of the victim to gain mastery of the memories associated with the rape (Doweiko, 1981). During the integration phase the counselor dealt with a) the victim's feelings toward self and b) the victim's feelings toward their assailant. Again, cognitive reorientation was applicable.

When successfully carried out, the results of this adjustment phase were individuals who accepted themselves as having been victims of rape without a need for self-blame or punishment. The goal was for victims to understand their role in the sexual assault as a victim.) Heppner and Heppner

(1977) listed the goals of the integration phase: identification and acceptance of feelings, reorientation of perception, attributions, self-statements, and resumption of a normal lifestyle.

Following a successful integration phase, Burgess and Holmstrom (1974b) found that the majority of rape victims were able to reorganize their lifestyle, stay alert to possible threats to their lifestyle, and focus on protecting themselves from further victimization. } Hilberman (1976b) was more pessimistic with reemerging issues being mistrust and avoidance of men, sexual disturbances, phobic reactions, and anxiety and depression often precipitated by seemingly trivial events which symbolized the original trauma.

(Throughout the three phase counseling process, there was no step-by-step progression to guide the counselor, only general signs by which the counselor judged whether progress was being made (Crum, 1976).)

Often advantageous to the rape victim was participation within a group counseling situation. Heppner and Heppner (1977) found that rape victims shared similar feelings and experiences, thereby creating a sense of normality. Victims learned from each other to reorganize their perceptions, attitudes and beliefs surrounding themselves and rape. Members provided a great deal of support in terms of acceptance and understanding. Finally, the group members encouraged each other as they proceeded to restructure their lives.

After the formal counseling relationship was over, the counselor had the responsibility of taking an active role to initiate follow-up contact with the victim (Hilberman, 1976b). Follow-up was particularly important in initiating a second gynecological examination. Soules, Stewart, Brown and Dollard (1978) reported that follow-up appointments in a sample of rape victims was successful in only six percent. In the case of the elderly

victim, follow-up was important due to possible isolation and reluctance to seek medical and social support assistance. The counselor of the elderly rape victim must also follow-up post-rape issues, such as medical concerns and victim safety (Hilberman, 1976b). Also, since the elderly victim was likely to be involved in a microenvironment, due to fewer human relationships and the lack of resources to make new ones, the counselor was likely to become an advocate, friendly listener, a companion, and someone who could give and receive affection (Wolff & Meyer, 1979). With these roles came the responsibilities of supporting the victim during the prosecution process, seeking financial aid to help defer legal expenses, and initiating home visits due to the elderly victim's possibly limited mobility (Burgess & Holmstrom, 1974b).

Grief Theory Emphasis. One strong commonality between the elderly woman and the rape victim was loss. With age the elderly woman often lost economical, social, and physical stamina. With rape came the losses of security, control, sexual identification, and even self-identity (Whiston, 1981). As Metzger (1976) pointed out, "Rape is loss, like death; it is best treated with a period of mourning and grief" (p. 405). Since one of the greatest fears of the elderly rape victim was death, this grief approach to rape was appropriate for the counseling of the elderly victim.

Freeman (1980) and Feiberg and Bridwell (1976) suggested that it was convenient and extremely useful to consider the rape victim's response as a form of grief reaction. Kubler-Ross (1969) described a grief reaction sequence of five "stages of death" through which dying patients approached their fate. These stages were: denial, anger, bargaining, depression, and acceptance. The first phase of the rape trauma involved fear, anxiety, and

a sense of being vulnerable. This phase was followed by the stage of denial during which the reality of the event and its consequences were ignored, refused or avoided. Denial was usually followed by guilt, characterized by "If only . . ." statements. Depression was frequently the next phase with shame, fear, humiliation, helplessness, and hopelessness. At this phase, Feiberg and Bridwell (1976) suggested that suicide was a possibility. As helplessness faded, anger began. This anger was often directed at men, institutions, physicians, police, courts, family, or any other person the victim perceived as having a role in her loss. As mentioned earlier, anger has historically been a socially unacceptable emotion for women, and due to the early socialization patterns of the elderly victim, impasse could be possible at this point in counseling. The appearance of anger signaled the process of integrating the rape into other life experience. Anger faded into integration while the victim began to return to a more stable emotional state and was able to begin life readjustment. As with after any loss or "death", the rape victim was unable to return to her "old self" in spite of the passage of time. Freeman (1980) hoped that the victim could develop a "new self" which was strong and self-reliant. As Whiston (1981) stated, "Of primary concern is the realization that the previous self-identity does not exist. The goal is to provide a means for the victim to develop a new self-identity that evaluates and incorporates the past experience using the losses and changes for growth" (p. 366). Through the use of this grief model in counseling the rape victim, the counselor was able to empathize with the victim since all counselors had suffered "partial deaths" (Fitzgerald, 1979). As Kavanaugh (1972, cited in Fitzgerald, 1979) stated "Anyone who has been touched by death or partial death may capture again many of the original emotions" (p. 27-28). Counselors who recognized and dealt with their own

grief processes were able to successfully and humanely work with those who faced losses through old age and rape.

Frequently, in the case of the elderly, depression and/or regression were viewed as a normal part of the old age developmental stage. But actually, such behaviors were adaptive defensive mechanisms responding to stress (Steury, 1976). The counselor must be sensitive to such mechanisms particularly exhibited by the elderly rape victim for these may well be defenses to pain within the grief reaction to rape.

Counselor sensitivity was also of paramount importance in discussing sexual issues with the elderly rape victim. Hammond and Sink (1980) found that many elderly women accepted and reacted to the "death" of their sexuality in much the same way as Kulber-Ross identified reactions to impending death. Actually, data suggested that sexual behavior did continue later in life and that this was part of the general adjustment of the elderly female (Christenson & Gagnon, 1965). Regardless of whether the elderly rape victim was sexually inactive or active, the counselor seemed able to anticipate sexual issues that often arose during counseling (Burgess & Holmstrom, 1979). The grief theory counseling emphasis was also helpful in dispelling the myths of sexuality and aging (Hammond & Sink, 1980).

Summary. The three theoretical approaches to rape counseling were:

1. The Crisis Theory approach which included crisis intervention, and long-term intervention after the rape occurred. The counselor as an information and referral source was also important, as well as an initiation of client follow-up. Three primary goals were established for the rape counselor. These were: a) establishing a sound working relationship which was supportive for the victim, b) providing practical legal and medical information, and

c) exploring long-term counseling needs. Although victim response patterns were generalized, individual response patterns were flexible, and counseling needed to be tailored to the individual. This individualized tailoring was especially important to the elderly rape victim since unique physical and social issues were involved with rape counseling.

2. The Developmental Stage/Coping Theory assumed that there were three phases of rape counseling. The victim's progression through these phases was often influenced by her developmental stage and coping behaviors. The phases were: acute reaction, outward adjustment, and integration. Throughout these phases the victim was encouraged to verbalize and express feelings of fear, anger, etc. associated with victimization. Issues considered with the elderly rape victim were different from the younger victim in this counseling approach because of the historical, social, and environmental variables that confronted her.

3. The Grief Theory emphasis seemed appropriate for the elderly rape victim since the losses that often occurred with old age and the losses that resulted from rape were affectively similar. As with rape, old age frequently meant the loss of security, control, sexual identification, and even self-identity. The victim's response to these losses was often as a form of grief reaction which the counselor needed to be cognizant of. Grief reaction often followed five stages: denial, anger, bargaining, depression, and acceptance; and to empathize with the victim during these stages the counselor was encouraged to recognize his/her own losses and grief processes. Counselor sensitivity was of utmost importance in dealing with issues of sexual loss while counseling the elderly rape victim.

Conclusions

Within this report certain conclusions appeared to be warranted.

- ✓ 1. Rape was a serious crime in the United States that was reported with increasing frequency.
- ✓ 2. Rape was an act of violence against a vulnerable female victim with sex being the tool of the aggression.
3. Elderly women reported being victimized by rape but in smaller numbers than did younger women. Reporting the rape was often confounded by social and personality variables of the victim.
4. The elderly woman was especially vulnerable to criminal victimization due to several developmental conditions and social beliefs associated with old age.
5. These developmental conditions and social beliefs impacted (either negatively or positively) on the counseling relationship with the elderly rape victim.
- ✓ 6. Rape counseling involved phases which were appropriate to the rape victim's reactions, such as acute reaction, outward adjustment, and integration phases.
- ✓ 7. The effective counselor was knowledgeable about the definition, prevalence, myths, and facts of rape.
- ✓ 8. The effective counselor utilized crisis, developmental stage/coping and grieving theories.
9. The effective counselor was knowledgeable about and sensitive to the elderly woman: her socialization, conflicts, strengths, fears, social roles, aspirations, and her individuality.
- ✓ 10. The effective counselor was able to tailor counseling to the rape victim while addressing the issues of age, femininity, and rape.

11. Counselors who were cognizant of their own sexual, developmental and social biases, who were able to face their own feelings of loss, grief and aging, and who remained sensitive to the needs of the client were successful in counseling elderly victims of rape.

Recommendations

Recommendations stemming from the report were:

1. Further research is recommended on the contrasts and comparisons between elderly and younger rape victims. Currently the literature on this association is sparse.
2. With the present increase in reported rapes and the "graying of America" (i.e., the number of elderly citizens in the United States is increasing which results in the average age of the United States population being higher) there is a likelihood that the cases of elderly rape will increase. This increase gives further evidence that the phenomenon of elderly rape should be investigated and studied in more depth.
3. Finally, since elderly victimization, not only rape, is of national concern further research needs to be conducted and strategies need to be developed to decrease the elderly person's vulnerability to victimization, and to develop preventive measures suitable to the elderly individual.

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Counseling Elderly Female
Victims of Rape

by

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AN ABSTRACT OF A MASTER'S REPORT

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Abstract

Rape is the fastest growing violent crime in America, and it has only been recently that the mythology of rape has been discredited. Many authors found that the majority of rapes occurred in the victim's residence, were planned in advance, and involved both physical and nonphysical force on the part of the assailant. It was also concluded that rape was an act of violence with sex being the tool for the aggression. This was particularly evident when the ages of women victimized by rape ranged from four months to 94 years.

Rape is also a vastly underreported crime, which served to disguise the true rate of elderly victimization. The estimated rate of elderly rape ranged from 2 to 19 per 1,000 population with the greater portion of rapes occurring in the homes of victims who lived alone.

The purpose of the report was to support the contention that for counseling of the elderly rape victim to be effective, issues different from those of the typical rape victim must be addressed, and that counseling should be tailored to the individual needs of the elderly victim. Specifically, variables that increased the elderly female's vulnerability to rape included physical, economical, environmental, historical-social, and psychological aspects of aging in America. The impact of these variables on the victim's reaction to rape and the counseling process was discussed in the report.

Three rape counseling emphases were introduced and evaluated as to their applicability to elderly female victims. The counseling approaches were: crisis theory, developmental stage/coping theory, and grief theory.

Other conclusions included the need for the counselors of the elderly rape victim to be knowledgeable of ageist and sexist issues, as well as for them to be cognizant of their own sexual developmental and social biases.

The counselors who are able to face their own feelings of loss, grief and aging, and who remain sensitive to the individual needs of the client will be successful in counseling elderly victims of rape.

Finally, recommendations for further research were included.