NCEA National Center on Elder Abuse

RESEARCH BRIEF

# Elder Sexual Abuse

**Sexual violence is a public health epidemic and human rights violation impacting millions of people worldwide.**[1] Globally, approximately one-third of women experience sexual and/or physical violence in their lifetime.[2] Offenses span a range of behaviors, from humiliation and harassment to assault. For survivors at the intersection of older age, sex, and abuse, elder sexual abuse (ESA) is often life-altering, resulting in consequential adverse physical, psychological, and social harms. Despite recognition of the phenomena, evidence of its prevalence, characteristics, impacts, and response is limited.[3] Research studies, policy initiatives, and practice proficiencies are needed to better recognize the unique needs of older survivors and effectively respond to mitigate harms and improve outcomes for survivors in later life.[4]

## Key Takeaways

- Elder sexual abuse is a public health epidemic and human rights violation impacting millions of older adults
- Elder sexual abuse is often shrouded in silence and shame by those experiencing harms and undetected by professionals who miss or minimize signs of abuse in later life
- Ageist misperceptions that paint older people, particularly women, as unattractive, asexual, and therefore impossible targets of sexual abuse contribute to under-reports by older adults, abuse under-detection, and inadequate provider responses
- The experiences of older survivors should be solicited and integrated into research and policy initiatives
- Collaborative, coordinated interdisciplinary intervention responses are needed to assess risk referral pathways, reporting processes, and supports

## Definition

**ESA crosses three discrete yet interconnected phenomena: sexual assault, intimate partner violence, and elder mistreatment.**[5] Sexual assault centers on non-consensual sexual conduct, regardless of age. Intimate partner violence addresses the nature and mechanisms of abusive relationships, but less so the sexual assault of older women.[6] Elder mistreatment is grounded in aging, health, and perceived susceptibility, but does not embrace sexual violence as an independent concept.[7] These constructs are rooted in differing definitional and theoretical conceptualizations of sexual injury, complexities that impact abuse disclosure, effective detection, and tailored response. Viewed through an intersectional framework, ESA is multi-dimensional, encompassing determinants of age, sex, health, power imbalance, and susceptibility.

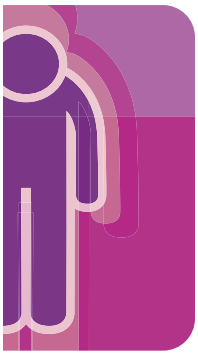
***ESA is often shrouded in silence and shame by those experiencing harms and undetected by undertrained professionals who miss or minimize signs of abuse in later life.***

Given the disparate elements that comprise and contribute to ESA, a universal definition of the concept is lacking.[8] In general, ESA is non-consensual sexual contact of any kind with an older adult, including but not limited to unwanted touching, sexual assault or battery, and sexual harassment. ESA also embraces sexual contact with older people who lack capacity to give consent[9] due to illness, cognitive condition, intoxication, duress, fraud, and undue influence. One study differentiates offenses by classifying them as "hands-on" and "hands-off" crimes. The former include rape, attempted rape, fondling, oral-genital contact, prostitution of the elder, sadistic sexual activity, or sexualized kissing. The latter offenses involve exhibitionism, voyeurism, sexual comments, and pornography.[10] Sexual violence may surface in the context of life-long harm or appear for the first time in later life.[11]

## Prevalence

**ESA is frequently underreported and undetected, resulting in inaccurate and vastly understated prevalence estimates.** Within community settings, one study found that 0.9% of older adults experienced ESA,[12] while another reported a prior year prevalence rate of 1.7%.[13] Within long-term care facilities, 1.9% of older residents care facilities experienced ESA.[14] Given the low reported frequency, ESA is considered the least prevalent and substantiated form of elder mistreatment. Underestimates are attributable to a number of causes, including methodological shortcomings, such as varying definitions of ESA ranging from corporal offenses to sexually harassing conduct.[15] Classifications of ESA as a subset of physical abuse rather than a distinct crime also dilute accurate prevalence rates.[16] Other factors masking reliable estimates are nondisclosure by elders and provider under-detection. As the population of older adults increases, rates of ESA are expected to rise.[17]

## Non-Disclosure and Under-Detection



### Non-disclosure

ESA is often shrouded in silence and shame by those experiencing harms and undetected by undertrained professionals who miss or minimize signs of abuse in later life.[18] Few older adults divulge sexual violence or seek professional help.[19] **One study found that up to 60% of ESA survivors never disclosed their experiences and 94% never sought formal help.**[20] Disclosure, if made, often occurs decades after the event.[21]

Challenges attendant to aging may inhibit the disclosure and detection of ESA. Poor physical health, cognitive deficits, frailty, and functional impairment, such as vision and hearing loss, may hinder reports of ESA. Social isolation may also impede identification. Older people may defer or decline reporting when the offender is a family member, caregiver, or trusted other on whom they depend for necessities. Many

may be trapped in abusive relationships or conflicted about incriminating a loved one and potentially subjecting them to prosecution. Some may not recognize non-consensual sexual violence within the context of marriage as ESA, but rather their spouse's right and their marital obligation.[22] Cultural norms, such as patriarchal views and generational beliefs about family cohesion may deter disclosure. Shame and embarrassment may further contribute to a conspiracy of silence surrounding the harms.[23]

## Under-Detection

**Healthcare professionals in primary, clinical, and emergency care settings are uniquely positioned to detect ESA**. They are among the first who come in contact with older patients and may identify cases of abuse.[24] Yet, owing to ageist social constructions of older people as asexual, many clinicians may not perceive older people as exposed to sexual assaults. They may also have limited diagnostic expertise in the forensic markers of ESA, and may mistakenly attribute injury to normative aging processes rather than intentional indicia of abuse.[25] Indeed, manifestations of ESA are rarely recognized or linked to sexual violence.[26] The lack of intervention protocols, including tailored and responsive resources, may further hinder appropriate harm-reduction responses.[27]

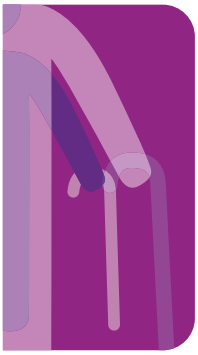
***Survivors do not typically reveal offenses to healthcare providers, preferring instead that professionals initiate the inquiry.***[28]

One study found that when professionals asked about abuse, patients disclosed incidents, leading to meaningful discussions. Conversations produced a "narrative effect," providing survivors a safe place to share, reconcile, and meaningfully resolve the facts and impacts of the harms experienced.[29]

## Help Seeking and Formal Supports

**For older adults who have experienced sexual violation, help-seeking is a complex process comprising several phases, each informed by feelings of shame, self-blame, ageist premises, and sexual taboos.**[30] Initially, survivors struggle with identifying the experience as ESA and often minimize the impact of injury. This leads many to the conclusion that they neither need nor are deserving of help. Next, survivors assess the availability of resources. In the final phase, they weigh the consequences of reporting, projecting the judgment and opinions of others amid fears of being disbelieved, concerns about implicating the offender, and reluctance to harm family relationships. Accordingly, most survivors prefer to cope on their own, without resort to community-based supports.[31] Mistrust of professionals and perceptions of ineffective institutional responses may further incumber outreach to formal resources.

## Ageism and Sexism



ESA occurs within the social construct of ageism, an insidious form of discrimination that may drive, even compound, under-reports, abuse under-detection, and inadequate provider responses. **Ageism refers to the way we perceive and treat people based on age.** Ageist misperceptions that paint older people, particularly women, as unattractive, asexual, and therefore impossible targets of sexual abuse, delegitimize acts of sexual violence against elders in later life.[32] Blanket mischaracterizations of elders as dependent and diminished are inaccurate and can seed misassumptions of older adults, aging, and abuse.

Age alone does not heighten susceptibility to sexual violence.[33] But age-associated health conditions may, in some cases, increase risk, exacerbate impacts, and/or inform support needs related to ESA.Significantly, older people experience offenses and express impacts in different and very personal ways.

Some survivors internalize ageist misassumptions propagated through social discourse, across media platforms, within employment domains, and societal structures. Self-directed ageism may induce shame, self-doubt, fear, and susceptibility, causing violated elders to discount or deny their lived experience, and even assume responsibility for crimes perpetrated against them.[34][35] Sexism also plays a role, as societal perceptions that stigmatize and objectify women sow further disadvantage and compound harms for older women.[36] Together these separate and socially isolate those who have been harmed by sexual abuse.

## Long-Term Care

**The prevalence of ESA in long-term care is estimated to be double that of the community, yet there is little data on the causes, characteristics, and frequency of abuse in this setting.** A constellation of factors is believed to contribute to harms. Cumulative chronic medical and functional conditions may increase the risk of ESA. Staffing insufficiencies, apathetic management, and ineffective regulatory requirements further a culture of secrecy and inhibit detection within facilities.

***Residents with cognitive decline may be unable to recognize and report abuse.***

If they do report, their accounts may be discounted without any investigation. As in the community, ageist misconceptions of older people as asexual and unlikely targets of sexual crimes hinder discovery of abuse. Internalized shame and emotional strife are ancillary impacts experienced by residents.[37]

Most incidents of sexual violence in facilities involve fondling, rape, and digital or object penetration, though non-contact assaults, such as exposure, harassment, and verbal sexual abuse have been reported. Some agencies have noted inappropriate sexual encounters and sexually suggestive images and videos of older residents posted on social media. Male residents and staff are the most common offenders.[38] A few facility

residents have been found to be criminal offenders with histories of sexual assault. Older women and residents with physical and cognitive impairments are at increased exposure. Injuries are often severe, resulting in long-term health consequences, including physical trauma, sexually transmitted infections, and psychological concerns.[39]

If detected and reported, complaints are typically made by family or facility personnel, not the resident. Studies have cited significant concerns regarding staff underreports, ability to recognize abuse, and appropriately respond to resident mistreatment.[40]

## Risk Factors

There are a number of factors associated with an increased risk of ESA involving older adults, offenders, and the context of their relationship.

### Older Adult

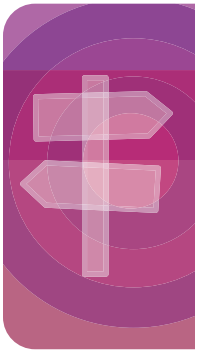
- ***Sex:* single, female, and widowed or divorced women experience abuse at significantly higher rates than men**
- Age: studies vary on the age range of those with greater exposure to harm; in the community, women in their 60s and 70s reported higher rates of mistreatment. In facilities, those in their 80s were more frequently subjected to sexual abuse
- Education and Income: lower educational status and lower incomes
- Health: physical, cognitive, and/or psychological impairments, and dependence on perpetrator for care or support[41]
- Social Isolation: living alone

### Offender

- ***Sex:* the vast majority are male**
- Age: some studies have reported perpetrators to be much younger that survivors, while others have found offenders to be similarly aged
- Criminality: prior criminal record
- Substance Abuse
- Quality of Relationship: within community settings, emotional or economic dependence on older adult

### Context

- Relationship: offenders are usually known to the elder; in the community, the most common perpetrators are spouses or other family members; in a facility, a caregiver or resident
- Setting: most often the older adult's home, except for survivors who reside in facilities
- ***Time of Day:* more frequent during hours of darkness**
- Assault Type: rape or penetration was the most frequently identified type, with extreme physical violence as the primary method of control, with significant harm inflicted[42]



## Signs and Impacts of Sexual Abuse

**Sexual assault is a life-altering event that can damage a survivor's sense of confidence and safety.**[43] Survivors at any age may experience physical, psychological, and/or social impacts. In later life, though, injuries can be more profound and persistent, resulting in greater harms and extended recovery times. ESA has been found to exacerbate existing medical and psychological conditions and contribute to long-term adverse health outcomes. Studies have suggested that ESA can be particularly harmful when the ability to self-protect is lower and susceptibility to injury higher.[44] While the full scope of long-term impacts is unknown given the lack of longitudinal studies exploring harms,[45] the following aftermaths have been observed:

### Physical Injury or Infection

- Physical injuries including and genital harm
- Strangulation injuries, such as shortness of breath, visual impairment, persistent cough, severe headache, abrasions, and swelling of the throat[46]
- Physical restraints and bite marks
- Difficulty sitting and walking
- Bruising of the soft palate at the junction of the hard palate
- Sexually transmitted diseases
- Incontinence
- Multiple bladder or urinary tract infections, particularly among facility residents
- Death[47]

### Behavioral and Psychosocial Changes

- Sleep disturbances
- Increased anxiety, withdrawal, depression, agitation, anger, and restlessness
- Incontinence
- Decreased enjoyment in activities
- Intrusive memories
- Coded disclosures
- Attempts to leave facilities in which they were assaulted
- Suicidality
- Post-traumatic stress disorder

### Maladjusted Coping Strategies

- Alcohol and drug misuse
- Men who reported recent sexual violence had a 20% higher odds of reporting binge drinking. Women who reported recent sexual violence had a 455% increased odds of reporting binge drinking
- Self-harm

### Social isolation

- Withdrawal[48]

## Resources and Recovery

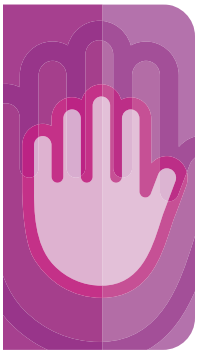
**In the aftermath of sexual abuse, older adults may not have the same or similar response.** Provider care and support may need to be individualized to that person. Survivors with physical and functional health conditions may suffer complex injuries or require sustained and particularized supports following abuse.[49] Mobility limitations may complicate medical and forensic examination.[50] Individuals with cognitive impairment can experience confusion and distress, which may impede counselling, consent for treatment, and forensic examination. Cognitive deficits may also be a bar to effective investigation and prosecution of offenses. Older survivors may have experienced cumulative life course stress and grief that may require a targeted response from knowledgeable professionals. Elders may also have unique housing and/or financial needs that impact access to resources.[51] Long-term care facilities may lack services and supports that residents may need to facilitate recovery.

With waning social connection in advanced age, survivors often have inadequate networks from which to draw support following mistreatment. Family, friend, and employment relationships are important to sustain recovery and foster wellbeing. Yet, many survivors disengage from community or experience the breakdown of close relationships, which can erode their quality of life and outcomes.[52]

## Gaps in Research

The paucity of research examining ESA has resulted in a significant gap in knowledge and informed practice.[53] Studies on intimate partner violence often do not address the prevalence, risks, and impacts of abuse in later life, and research in the area of elder mistreatment frequently excludes inquiry regarding sexual violence.[54] Variability in research methodology has also contributed to deficits. Studies in elder mistreatment tend to be quantitative, focused on prevalence, while intimate partner and sexual violence research is often qualitative, trained on the nature and consequences of crimes. Contributing to the chasm in knowledge, the lived experiences of older survivors are rarely integrated into research. Separately, there is scant data on the abuse of older men, and perpetrators.[55] [56]

## Intervention



Following are some recommendations to improve proficiencies across practice, research, policy, and educational domains.

### Practice

- Engage interdisciplinary professionals in collaborative and coordinated prevention, screening, detection, risk assessment, and response through referral pathways, reporting processes, and supports
- Integrate a lifespan approach to sexual health to enhance prevention through holistic screening and assessment

- Make recovery services available in long-term care settings
- Understand that the impacts, expressions, experiences, and contexts of ESA may differ from those of younger victims
- Learn the signs of ESA among older survivors, including sexually transmitted diseases
- Encourage providers to engage in sensitive conversations with older survivors to surface undisclosed abuse and create a safe space to discuss harms
- Recognize the maladaptive coping strategies, such as alcohol abuse, that may signal ESA and assist survivors in identifying and adopting positive approaches to address harms

## Research

- Include the experiences of older survivors, including those from various backgrounds and communities
- Examine the longitudinal impacts of ESA
- Explore the intersection between age, sex, and ESA
- Investigate the role of third parties, such as family, friends, and staff, to prevent ESA within the community and long-term care facilities
- Draw from relevant theories to understand and inform prevention efforts and more effective practices

## Policy

- Integrate the voices and experiences of older survivors in policy initiatives
- Investigate how care for harmed elders of recent and non-recent SV can be more available, acceptable, and affordable
- Adopt policies that protect older survivors with physical, functional, and/or cognitive impairments
- Develop policies that address and eliminate ageism and its harmful effects

## Education

- Increase interdisciplinary training for professionals working with older adults to screen, assess, detect, and respond to ESA
- Build professionals' competence and skills in addressing the unique needs of survivors of later life abuse

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# Endnotes


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