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SEXUAL ASSAULT AGAINST OLDER ADULTS

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Increasing Access to Justice for Older Adult Victims of Sexual Assault: A Capacity Building Approach
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1.0 INTRODUCTION

As a rapidly growing demographic group (Brennan, 2012; Dauvergne, 2003), persons aged 65 years and older represent almost one-fifth (17%) of the Canadian population (Statistics Canada, 2016). For the first time in Canadian survey history, Canada's seniors outnumber its children (Conroy, 2017, p. 66; Globe and Mail, 2017). Accordingly, an interest in the abuse of older persons has emerged (Burczycka & Conroy, 2017; Ploeg, Lohfeld & Walsh, 2013). Research suggests that anywhere from four to 10 percent of Canadian seniors (aged 65 years and older) experience some form of abuse, yet only a fraction of these cases come to the attention of authorities (Conroy, 2017, p. 66; Public Health Agency of Canada, 2012). Internationally, including Canada, elder abuse, or the abuse of older adults, refers to "a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person" (World Health Organization 2002). Elder abuse can take the form of neglect, physical, sexual, emotional, or financial abuse (Public Health Agency of Canada, 2016; Burczycka & Conroy, 2017; Ploeg et al., 2013). In general, elder abuse has been identified as a matter of global concern (Baker, Sugar, & Eckert, 2009; WHO, 2013), but compared to other forms of

violence it has received relatively little attention until recently. Given this, the sexual abuse[1] of older adults has received minimal attention in the literature and in practice (Bows, 2017, 2017b; Browne, Hines, & Tully, 2016; Burgess, 2006; Burgess, Lamport Commons, Safarik, Rockwell Looper, & Ross, 2007; Collins & O'Connor, 2000; Fileborn, 2016; Jeary, 2004; Jones & Powell, 2006; Johannesen & LoGiudice, 2013; Malmedal, Iversen & Kilvik, 2014; Ramsey-Klawsnik, 2003; Thomas et al., 2014), especially in Canada (Dauvergne, 2003; Del Bove, Stermac, & Bainbridge, 2005; Grant & Benedet, 2016; McDonald, 2011; Ploeg et al., 2013; Poole & Rietschlin, 2012).

Existing research is predominately found within the fields of criminology, elder abuse, and domestic violence, but what is known about sexual abuse against older adults remains incomplete because there are few studies with this specific focus (Bows, 2017; Fileborn, 2016). This is increasingly problematic because the number of older persons who are sexually abused is expected to continue to increase with the growth in the aging population internationally (Burgess et al. 2005; Cook et al., 2011; Craig, 2000; Dauvergne, 2003; Grant & Benedet, 2016; Greenlee, 2012; Johannesen & LoGiudice, 2013; Pinto, 2011; Ploeg et al., 2013; Safarik, Jarvis, & Nussbaum, 2002; Shiamberg & Gans, 2000; Zink & Fisher, 2006). Canadian research on the incidence and nature of sexual abuse against older adults is particularly lacking. Most research has been conducted in the United States, with some research in Australia, or the United Kingdom (Ball,

[1] We use the term 'sexual abuse' to capture various forms of abuse and violence that exist along a continuum of victimization from inappropriate touching to sexual assault and rape. In reviewing the literature, where there are distinctions in experiences, these will be noted, and the most appropriate terminology applied.

2005; Grant & Benedet, 2016). As a result, what we know about sexual abuse against older adults in Canada is quite limited, but information from other countries can help us identify knowledge gaps and research priorities.

The current literature review is designed to provide an overview of the knowledge base and research on sexual abuse of older adults. It includes a focus on the key issues in the study of sexual abuse of older adults, risk factors for victimization and perpetration, as well as consequences and outcomes of sexual violence against older adults. It concludes with a section summarizing key recommendations and suggestions for future research, policy, and practice.

2.0 IMPORTANT CONSIDERATIONS: TERMINOLOGY, GENDERED AGING, AND PREVALENCE

While sexual abuse across the lifespan is vastly underreported for most victims, sexual abuse of older adults is described as the most underreported and least acknowledged type of elder mistreatment (Bonnie & Wallace, 2003; Brozowski & Hall, 2010; Burgess, Dowdell, & Prentky, 2000; Cannell et al. 2014; Muram et al., 1992; Malmedal, Iversen, and Kilvik, 2014; Ramsey-Klawsnik, 1998; Roberto & Teaster, 2007). Sexual assault of older women is also more underreported than sexual assault of younger women (Cartwright & Moore, 1989; Del Bove et al., 2005; Groth, 1978). This is due, in part, to several challenges specific to this population which impede their access to community and justice resources and services**.** These include, and will be discussed in more detail below, language and cultural barriers, physical and mental impairments, as well as inexperience with technology can impact identification, disclosure, reporting, and help-

seeking in the aftermath of abuse, further increasing the vulnerabilities of the aging population (Conroy, 2017; Government of Canada, 2014; Sev'er, 2009). As a result, while we know that sexual abuse of older adults is occurring, the true extent of this problem is difficult to estimate and, therefore, it is recognized that any documented incidence and prevalence rates are underestimates (Bows, 2017; Del Bove et al., 2005; Grant & Benedet, 2016; Groth, 1978; Jones et al., 2009; Pinto et al., 2014).

In addition, diversity in definitions of 'old age' and conceptualizations of sexual abuse or violence, particularly among this demographic group, as well as variations in methodologies and sampling designs used in different studies, impact the prevalence estimates of sexual abuse among older adults, precluding accurate comparability and generalizability of research findings (Bows, 2017; Biggs et al., 1995; Cook, Dinnen, & O'Donnell, 2011; Neale et al., 1996; Ploeg, Lohfeld, & Walsh, 2013; Shiamberg & Gans, 2000). The following sections will discuss some of these considerations in more detail as they relate to the literature on sexual abuse of older adults.

2.1 What Constitutes Old Age?

Within the literature on sexual abuse of older adults, there is a lack of agreement on what exactly constitutes old age (Bows, 2017, 2017b; Fileborn, 2016; Grant & Benedet, 2016). Defining 'older' and who is 'old' or 'elderly' varies culturally and historically (Kleinschmidt, 1997; Pinto, 2011; Tyyska et al., 2012). Between 45 and 65 years of age appear to be the most commonly used

cut-off points to represent the lower bounds of old age in the literature (Grant & Benedet, 2016); however, chronological age is not the only marker used. Some researchers use physiological indicators such as menopause, socio-cultural indicators such as retirement, or define old age across multiple categories of early, mid, and deep old age, with labels such as young-old, mid-old, and old-old being applied (Aciemo et al., 2010; Brozowski & Hall, 2010; Del Bove et al., 2005; Fileborn, 2016; Jones et al., 1999; Ondeck, 2002; Pinto, 2011). Specifically, in Canada, the age at which one becomes an older adult has been cause for debate (Turcotte and Schellenberg, 2007), however, it has typically been defined as 65 years of age and up (Department of Justice, 2015). While terminology is vast throughout the literature, 'older adult', 'older person', or 'elder' will be the preferred terms utilized in this review.

2.2 What Constitutes Sexual Abuse of Older Adults?

The terminology used to describe sexual violence against older adults also varies in the literature. The general trend is the use of the term 'sexual assault' incorporated with an old age descriptor to denote instances whereby the victim experienced sexual violence at the hands of a stranger and, usually, in an isolated incident. 'Sexual abuse,' on the other hand, appears to be the preferred term in studies describing sexual violence experienced by older adults at the hands of known perpetrators and over a prolonged period or across multiple instances. Other researchers have used sexual abuse instead of sexual violence to account for a broader range of sexual acts perpetrated towards or against older adults (Poole & Rietschlin, 2012). Despite these apparent

differences in terminology, there is no clear consistency, as sexual abuse, sexual assault, and sexual violence perpetrated against older persons are often used interchangeably. There are also differences in the literature on what acts are captured by sexual abuse or sexual assault of older adults (Benbow & Hadad, 1993; Cooney & Howard, 1995; Lachs & Pillemar, 2015; Payne, Berg & Byers, 1999). This is largely because there is no agreed upon universal definition of sexual abuse against this group (Bows, 2017; Malmedal, Iversen & Kilvik, 2014; Pillemer & Finkelhor, 1988; Shiamberg & Gans, 2000; Von et al., 2017). The lack of a universal definition or understanding of elder sexual abuse leads to problems assessing its incidence and prevalence.

In designing and/or adopting appropriate definitions of sexual abuse of older adults, it is important that they are broad enough to account for a range or variety of experiences, yet specific enough to be distinguishable from other types of abuse against older adults (Cannell, 2013; Benbow & Haddad, 1993; Ogg & Bennett, 1992; Ramsey-Klawsnik, 1991; Johannesen & LoGiudice, 2013; Muram et al., 1992). However, many studies in the literature simply include sexual abuse as a subset of physical abuse against older adults (Ahmad & Lachs, 2002; Benbow & Haddad, 1993; Bows, 2017, 2017b; Brozowski & Hall, 2010; Crichton et al., 1999; Grant & Benedet, 2016; Kleinschmidt, 1997; Penhale, 2003; Poole & Rietschlin, 2012). This is problematic because if sexual abuse is not recognized as a distinct form of abuse, researchers fail to capture the diversity of victimization experiences among older persons. This can obscure prevalence statistics, making analysis of sexual violence against older people difficult and the design of interventions a challenge (Bows, 2017; Giordano & Giordano, 1984). This is largely the case with the prevalence

statistics reported in the Canadian literature, because despite asking distinct questions about different types of abuse, studies using larger, community-based samples tend to combine physical and sexual violence incidents in their reports (Brennan, 2012; Brozowski & Hall, 2010; Grant & Benedet, 2016). Further, while some estimates describe the proportion of older persons who experience sexual violence, other estimates describe the proportion of sexual violence victims that are older, restricting the ability to draw meaningful comparisons across studies (Bows, 2017). Prevalence rates of sexual violence reported in larger-scale population studies[2] of community dwelling older persons tend to be the lowest, while rates reported in studies based on convenience samples[3] of victimized or institutionalized older persons are higher (Bows, 2017). As a result, the existing data are limited and should be interpreted with caution.

To address these limitations in the definition and measurement of sexual abuse against older adults, some researchers have developed their own unique definitions of sexual abuse (Daly, Merchant, Jogerst, 2011; Buri et al., 2006; Johannesen & LoGiudice, 2013; Johnson & Sigler, 2000; Muehlbauer & Crane, 2006; Payne, 2000; Salvesen & Jeffreys, 1999). Overall, as a combination of sexual abuse and elder abuse, sexual abuse of older adults is typically defined as non-consenting sexual contact that includes behaviours from coerced nudity and sexually-explicit

[2] Population-based studies utilize recruiting and sampling techniques designed to elicit samples that are representative of the population. The goal of these studies is to generalize the findings to the larger population, and thus samples are typically quite large. An example is Statistics Canada's General Social Survey (GSS) on victimization.

[3] Research that utilizes convenience samples employ recruitment techniques to obtain a sample specifically because of a trait, experience, or other characteristic. These samples are not necessarily representative of the population, and are typically much smaller, and therefore the findings are not generalizable. Examples include studies of sexual violence victims recruited at hospitals, police stations, or different community service organizations; also case records at different agencies.

photographing to unwanted touching and sexual assault including rape and sodomy (Brozowski & Hall, 2010; Cannell et al., 2014; National Centre on Elder Abuse, 1998, 2011). A useful description of sexual abuse against older adults as a continuum of hands-off and hands-on behaviours is provided by Ramsey-Klawsnik (1991, 2003). At one end of the continuum are hands-off behaviours which include exhibitionism, voyeurism, and forced pornography. At the other end, are hands-on behaviours which include touching, physical molestation, oral-genital contact, forced penetration, and genital or rectal care or hygiene practices that are unnecessary to the older victim (Burgess, 2006; Ramsey-Klawsnik, 2003; Johannesen & LoGiudice, 2013).

While specific definitions of sexual abuse of older adults are better able to capture the realities faced by aging victims of sexual violence, inconsistencies in these definitions and markers for old age significantly impact the ability to make comparisons and to draw conclusions about common characteristics as well as barriers in the prevention, recognition, and reporting of sexual abuse against older adults (Bows, 2017; Kleinschmidt, 1997). The remainder of this section will discuss the importance of analyzing sexual violence of older adults through an intersectional lens, given that gender and age interact also combine with other variables to create varying levels of risk and vulnerability for sexual violence victimization among older adults.

2.3 The Paradoxes of the Aging Adult: A Gendered Process

The recognition of Canada's aging population as representing a diverse generational cohort is important for prevention, intervention, and programming. However, if we view older persons as

a homogenous group, we fail to account for the different challenges evident throughout the various life stages (Grant & Benedet, 2016; Turcotte & Schellenberg, 2007). Old age is a culturally-specific and socially-constructed phenomenon that is also highly gendered, especially within the context of sexuality (Bows, 2017; Grant & Benedet, 2016; Fileborn, 2016; Pinto, 2011; Ontario Women's Dialogue Project). Women are viewed as older at a younger chronological age than men and, while an aging male may still be viewed as sexually alluring or distinguished (Crichton et al., 1999), aging women are often viewed as unattractive (Crichton, Bond, Harvey, & Ristock, 1999), asexual (Burgess, 2006; Fileborn, 2016; Solomon et al., 2011; Nyanzi, 2011), and even useless (Ron & Lowenstein, 1999), although there is a movement to change such images and stereotypes.

By viewing older persons, and particularly women, as asexual, they may be ignored as potential victims of sexual abuse or assault (Grant & Benedet, 2016; Poulos & Sheridan, 2008; Cannell et al. 2014). This has implications, not only in terms of defining sexual abuse against older adults, but also in terms of recognizing, preventing, and intervening in these cases. It is not common for researchers to acknowledge the intersection of violence and aging (Bows, 2017; Brandl, 1997; Fisher & Regan, 2006; Fisher, et al., 2004; Vinton, 2003; Wilke & Vinton, 2003) because older women have traditionally been overlooked in literature pertaining to violence against women and intimate partner violence more generally (Crockett et al., 2015; Fisher, Zink, & Regan, 2011; 2003; Zink et al., 2004). This omission is especially problematic when we consider that sexual abuse is highly gendered across the life course, including among older victims (Crichton et al., 1999; Penhale, 2003; Fileborn, 2016; Grant & Benedet, 2016). That is, perpetrators

of sexual abuse towards older persons are almost always male (Crichton et al., 1999; Grant & Benedet, 2016; Penhale, 2003) and victims are overwhelmingly female (Bows, 2017; Brozowski & Hall, 2010; Bows and Westmarland, 2017; Cannell, Manini, Spence-Almaguer, Maldonado-Molina, & Andresen, 2014; Del Bove et al., 2005; Crichton et al., 1999; Dyer & Rowe, 1999; Grant & Benedet, 2016; Johannesen & LoGuidice, 2013; Ball & Fowler, 2008; Gorbien & Eisenstein, 2005; Luoma et al., 2011; Pinto, 2011; Soares et al., 2010). This is not to say that elder sexual assault is a strictly heterosexual experience, as this type of abuse likely does occur among older persons within same-sex relationships as well across diverse genders, however the research is lacking substantially. Nevertheless, reports on the findings from three different online surveys of transgender adults over the age of 40 on sexual violence, elder abuse, and sexuality, found that 18 percent of respondents indicated they experienced unwanted sexual touch between the ages of 41 and 60 years of age (Cook-Daniels & Munson, 2010). There is a lack of research reporting the sexual victimization experiences of older females in queer relationships. This omission could be related to a variety of reasons, including but not limited to generational stigma regarding same-sex relationships. Results from a Canadian qualitative study of marginalized older women's perceptions of elder abuse, found that none of the women who identified as lesbian identified sexual abuse as a component of elder abuse unless prompted by interviewers (Ploeg et al., 2013).

It is also crucial to recognize that embedded within societal misunderstandings about sexual assault is the view that these crimes are fueled by sexual desire (Baker, Sugar, & Eckert, 2009; Muram, Miller, & Cutler, 1992). The belief in rape as an expression of passion, coupled

with the ageist assumption that older adults are asexual and not vulnerable to sexual abuse, makes acknowledging sexual violence against an older person difficult (Brozowski & Hall, 2010; Jeary, 2004; Jones & Powell, 2006; Iversen, Kilvik, & Malmedal, 2015; NCALL, 2010; Roberto & Teaster, 2007; Safarik et al., 2002). Most theoretical accounts of sexual abuse/assault of older adults explain it as victimization that involves the use of power and control over a vulnerable person, not passion (Crichton et al., 1999; Pollock, 1988).

It has been argued that in general, older women are more vulnerable than younger women to crime (Safarick et al., 2002) because of their deteriorating health, restricted mobility and strength, changes in cognition and other mental facilities, increases in loneliness and isolation, and dependence on caregivers (Jeary, 2005; Safarik et al., 2002; Simmelink, 1996; Soares et al., 2014). While sexual victimization has traumatic physical and emotional effects at every age, the vulnerabilities experienced in one's older age make it particularly harmful (Grant & Benedet, 2016; Jeary, 2005; Ramsey-Klawsnik, 2003). For example, older women have a decreased ability to engage in self-defence and an increased likelihood of incurring injuries (Cartwright, 1987; Eckert & Sugar, 2008; Jones et al., 2009; Muram, Miller & Cutler, 1992; NCALL, 2010; Payne, 2000; Ramsey-Klawsnik, 2003). Despite these increased vulnerabilities, older people, and specifically women, tend to underestimate their vulnerability to abuse (Hussein, Manthorpe, & Penhale, 2007) and/or fail to recognize abusive experiences as such (Naughton et al., 2013). Therefore, not only does society underestimate the possibility and likelihood of sexual abuse against older adults, so too do potential or actual victims. It is only recently that sexual violence

against older people, and more specifically older women, has been identified as occurring in a wide range of settings and under a wide range of circumstances (Bows, 2017; Burgess & Clements, 2006; Jeary, 2005; Mann, Horsley, Barrett & Tinny, 2014). This is, in part, due to its attention by health care providers, law enforcement agencies, and protective services over the last decade (Muehlbauer & Crane, 2006). Nevertheless, the inconsistencies and variations in what constitutes old age and the sexual abuse of older adults, as well as the relative neglect of older women in sexual violence research, severely impede the ability to generalize about the prevalence of sexual abuse of older adults and more specifically older women. In addition, current research consists mainly of descriptive, observational, and case studies of older victims of sexual abuse with some literature focusing on perpetrators as well as formal responses to such victimization. Keeping these issues in mind, the next section describes the research that has been conducted to date on the prevalence of sexual violence victimization among older adults, the correlates, health impacts, and outcomes of this type of violence, and the institutional and criminal justice responses in the aftermath of sexual violence victimization of older adults.

2.4 What is the Estimated Prevalence of Sexual Violence Victimization?

As previously discussed, although there is no agreed upon consensus of what constitutes old age, and there are variations throughout the literature (Bows, 2017; Fileborn, 2016; Grant & Benedet, 2016), the most commonly used the lower bounds of old age tend to be 45 to 65 years of age (Grant & Benedet, 2016). Prevalence rates of sexual violence victimization reported in large community-based surveys of older adults range from approximately 0.6 percent to four percent of

the population studied (Aciemo et al 2010; Bows, 2017; Cannell et al., 2014; Eisikovits, Winterstein, and Lowenstein, 2004; Fisher & Regan, 2006; Hussein, Manthorpe, & Penhale, 2007; McDonald & Collins, 2001; Naughton, Drennon, Lyons, & Lafferty, 2013; Soares et al., 2014). Using data from the sexual violence module in the 2005 Behavioral Risk Factor Surveillance System (BRFSS), one study examined the health and health-related behaviours among community-dwelling adults in the United States. The study authors, Cannell and colleagues (2014), found that 0.9 percent (N=90,289) of older adults 60 years old and older experienced sexual abuse in the previous year. Similarly, results based on the National Elder Mistreatment Study which examined community-residing adults aged 60 years of age and older in the United States (N=5,777) demonstrated that the prevalence of previous-year sexual mistreatment was 0.6 percent (Aciemo et al., 2010). Similar, albeit slightly higher estimates were reported internationally by Luoma and colleagues (2011) who conducted a large-scale population-based survey among community residing women (aged 60 – 97 years) in five countries in the European Union and found that just over three percent of all women in the study (N = 2880) reported sexual violence. More specifically, in the previous 12 months, approximately 2.1 percent of older adults in Austria, 2.4 percent in Belgium, 4.7 percent in Finland, 2.3 percent in Lithuania, and 3.6 percent of women in Portugal reported having experienced sexual abuse (Luoma et al., 2011). It should be noted however, this study utilized four different measures of varying degrees of sexual abuse, and thus, this could be impacting the slightly higher prevalence rates in this study compared to the US research that utilizes fewer or less detailed indicators.

There is a dearth of Canadian data on estimates of elder sexual abuse in the population (Benedet & Grant, 2014; Poole & Rietschlin, 2012) To date no population-based estimates specific to this population has been located (*but the search continues*). The trend in the nationally-representative Canadian victimization studies on older adults is to combine the categories of physical and sexual violence[4] (Brozowski & Hall, 2010; Crichton et al., 1999; Grant & Benedet, 2016; Poole & Rietschlin, 2012) which limits the ability to assess the prevalence of sexual violence against older adults, independent of other physical types of abuse or violence. Results of these studies should not be discounted, however, as they provide a starting point in understanding the pervasiveness of abuse among older victims in Canada. For instance, Canadian estimates suggest that approximately four to 10 percent of older persons are victims of violent crimes (including, but not limited to, sexual assault) (Brozowski & Hall, 2010; Brennan, 2012; Podnieks, 1992). Prevalence statistics are lower when restricting experiences to those acts perpetrated by a current or former spouse/partner in the preceding five years because less than one percent of older Canadians reported experiencing this type of victimization (Brennan, 2012; Poole & Rietschlin, 2012). Recall, however, that most cases of sexual abuse and violence go unreported to official authorities particularly if perpetrated by a spouse/partner or family member. Therefore, the extent

[4] It should be noted that the combination of physical and sexual violence does not appear to be at the level of the data, and instead appears to have been done for analysis. With Statistics Canada data, such as the Canadian GSS, researchers must apply for and be granted access to the raw data through a Research Data Centre (RDC). It is within these RDC's that data analysis is conducted by researchers, who must have their analyses vetted and approved prior to it being released. However, restrictions on cell counts, weights, and rounding of raw numbers must be adhered to, and as a result, sometimes variables are collapsed or merged to meet this requirement. It is likely, that this is the case for much of the Canadian population-based analyses on sexual violence of older persons.

of sexual violence against older people is likely to be much higher than is currently known (Bows, 2017; Burgess, 2006; Grant & Benedet, 2016; Fileborn, 2016).

Independent of geographical location, smaller studies using convenience samples of victims or case reports of sexual violence have slightly higher proportions of older victims of sexual abuse than population-based surveys, ranging from between two and eight percent (Bows, 2017; Grant & Benedet, 2016; Muram, Miller, & Cutler, 1992). Among women attending rape crisis centres or sexual assault clinics, in the United States and internationally, estimates indicate that about three to six percent of victims are older (Jones et al., 2009; Scriver et al., 2013; Lundy & Grossman, 2004; Muram. Miller, & Cutler, 1992). For instance, among women attending sexual assault clinics and/or emergency departments in three counties in west Michigan USA, Jones and colleagues (2009) found that four percent of the victims were aged 50 years or older. Likewise, Fisher and Regan (2006) found that, among women attending community care clinics in Southwestern Ohio, three percent of victims were over 60 years of age and, similarly, Lundy and Grossman (2004) found that among persons aged 65 years of age and older who entered domestic violence programs in the United States, approximately five percent were victims of sexual violence. Specifically focusing on sexual violence by an intimate partner yields slightly lower rates. For instance, researchers who examined intimate partner violence among women 55 years and older who attended primary care offices in middle western United States found that about two percent of older women were sexually mistreated by an intimate partner since the age of 55 and

less than one percent experienced sexual mistreatment by someone other than an intimate partner (Zink & Fisher, 2006).

International estimates are similar. In Ireland, Scriver and colleagues (2013) reported that six percent of sexual assault service users were 55 years of age or older, while in a study of 150 recorded instances of elder abuse derived from a telephone support "help-line" pilot program for older community-residing Japanese persons residing in Japan, or the United States, less than one percent of cases involved sexual abuse (Anetzberger & Yamada, 1999).

Consistent with these various country-specific findings are those reported in a comprehensive case law review of sexual assaults over a period of two decades in Canada (1995-2015). In that study, Grant and Benedet (2016) reported that almost four percent of cases of sexual violence (N=3,000) throughout Canada involve older complainants (aged 55 years or older).

In summary, although it is difficult to draw concrete generalizations from Canadian studies, when combined with research largely conducted in the United States, it is evident that with the continued growth in our aging population, sexual abuse of older adults continues to be a pervasive problem. While known statistics only represent the tip of the iceberg (Dyer & Rowe, 1999), the available literature can still provide us with information on the various correlates concerning the sexual abuse of older persons, providing further crucial context to the experiences of these victims.

3.0 SEXUAL ASSAULT OF OLDER ADULTS: CHARACTERISTICS OF VICTIMS & PERPETRATORS

Identifying risk factors for sexual abuse among older adults can be difficult, as there are vast differences in definitions, methodologies, and findings as discussed above (Bows, 2017). Findings also vary based on the type of sexual violence experienced, which is most clearly distinguished by the nature of the relationship between the victim and perpetrator. Sexual abuse of older adults can be distinguished by five primary types of victim-perpetrator relationships: (1) stranger or acquaintance sexual assault; (2) incestuous abuse by a family member or pseudo-family member; (3) intimate partner violence; (4) abuse by an unrelated care provider; and (5) resident-to-resident abuse within care facilities (Bows, 2017; Ramsey-Klawsnik, 1998). The first three types are reported more in studies of community-residing older adults. The last two comprise most cases described in studies conducted in residential care facilities intended for older adults. However, with the growing movement to provide in-home care for older persons, abuse by an unrelated care provider may be increasingly more likely to occur in the home as well. Despite this, where the victim resides is also a primary characteristic that can differentiate the nature of sexual violence experienced by older adults, victim, perpetrator and incident characteristics, and identification, disclosure, and reporting of the abuse. The following subsections will review the most common factors involved in sexual violence against older adults and will conclude with a brief discussion of some of the lesser common factors which are worth mentioning given that research remains in its infancy and they may become more relevant as our knowledge base grows.

3.1 Gender

While risk factors tend to vary by residential location, the gendered aspect of sexual violence against older victims discussed above is consistent across locations. Older women are much more likely than older males to be victims of all forms of mistreatment, including sexual abuse and violence (Cannell et al., 2014; Conroy, 2017; Crichton et al., 1999; Dietz & Wright, 2005; Grant & Benedet, 2016; Jeary, 2005; Zink & Fisher, 2006; Melchiorre et al., 2016; Pinto et al., 2014). In addition, men are much more likely to be perpetrators of sexual abuse against older persons, regardless of the location in which the violence takes place (Crichton et al., 1999; Del Bove et al., 2005; Grant & Benedet, 2016; Jeary, 2005; Pinto et al., 2014). Results suggest that, even when men are sexually victimized, their abusers are primarily other men who are their caregivers, acquaintances, or friends with mental health impairments, often residing in the same residential facility (Burgess et al., 2007; Jones & Powell, 2006; Roberto & Teaster, 2007; Teaster et al., 2007). In contrast, cases involving female perpetrators are rare, but have been reported for female care providers sexually abusing clients (Burgess et al., 2000; Payne, 2010; Roberto & Teaster, 2007), wives sexually abusing their elderly husbands (Crichton et al., 1999; Ramsey-Klawsnik, 2003), granddaughters or other female relatives sexually abusing older relatives including via intrusive, painful, or unwarranted genital practices (Chihowski & Hughes, 2008), and daughters abusing their older parents more generally (Crichton et al., 1999; Teitelman, 2006). Such cases of female-perpetrated sexual abuse of older adults tend to emerge in the literature as isolated case studies. Therefore, the only conclusion that can be drawn is that, although sexual

victimization of older males does occur, it is most often at the hands of other males and occurs much less frequently than sexual abuse and violence of older women.

Canadian prevalence estimates based on gender are incomplete, however. For instance, while Brozowski and Hall (2010) conducted a population-based analysis of the 1999 Canadian General Social Survey to explore experiences of sexual violence among older adults, in their report, physical and sexual violence items were collapsed into a global measure of physical/sexual violence, precluding any conclusions about gender and sexual violence specifically. Despite this limitation, their findings are in the expected direction, indicating that women aged 65 to 80 years of age in Canada report experiencing physical or sexual assault almost three times more frequently than similar aged men (Brozowski & Hall, 2010, p. 1194). This trend has remained relatively stable over the years, with older women experiencing family violence (including, but not limited to, sexual violence) at a rate that is 26 percent higher than that of older men (Conroy, 2017). Moreover, among the 109 identified case law instances of sexual violence against older adults in Canada, only three victims were male (Grant & Benedet, 2016), highlighting the disproportionate number of female victims of sexual violence compared to male victims, at least with respect to those that were reported to and progressed through the criminal justice system.

Further building on gender differences in experiences of sexual violence among older adults is the finding that there exists an interaction effect between gender and binge drinking among older victims of sexual abuse. More specifically, in their community survey of adults aged 60 years or older throughout 18 states in the United States, Cannell and colleagues (2014) reported

there were no differences in the proportion of male and female victims of recent sexual violence among those who did not binge drink. However, among those who did binge drink, gender differences emerged: men who reported recent sexual violence had 20 percent higher odds of also reporting binge drinking, while women who reported recent sexual violence had 455 percent increased odds of also reporting binge drinking. The gendered nature of sexual violence among older victims is evident. Females are typically victims, and males are typically perpetrators.

3.2 Age

Age is a commonly-discussed correlate in the victimization literature. Findings suggest that among older adults, being younger is typically associated with a greater risk of all types of abuse including sexual violence (Brennan, 2012; Cook et al., 2011; Cooper & Crockett, 2015; Crichton et al., 1999; Lach & Pillemer**,** 2015; Poole & Rietschlin, 2012; Sinha, 2013). However, these findings are not clear cut. Although younger Canadians are more likely than older Canadians to self-report sexual assault experiences (Brennan, 2012), Canadian research shows that, when compared to younger (15-30 years) and middle-aged female victims (31-54 years), older female victims (55+ years) of sexual violence were more likely to live alone and to have physical and cognitive impairments, underscoring the heightened vulnerabilities specific to older women with respect to their risk of sexual abuse (Del Bove et al, 2005). Age and risk of sexual abuse in older adults is also related to the victims' location of residence – whether they reside in the community or in a residential care setting. Research conducted with community-dwelling older adults suggests

that the young-old (in their 60s and 70s) experience sexual violence at rates higher than the oldest-old (those in their 80s) (Baker, Sugar, & Eckert, 2009; Ball & Fowler, 2008; Bows and Westmarland, 2017; Jeary, 2005; Lea, Hunt, & Shaw, 2011; Naughton et al., 2010; O'Keefe et al., 2007). In residential care settings, this relationship changes: the oldest-old (aged 79 and up) experience the highest rates of sexual abuse compared to the young-old (Baker et al., 2009; Bows, 2017; Burgess, Dowdell, & Prentky, 2000; Eisikovits, Winterstein, and Lowenstein, 2004; Ramsey-Klawsnik, Teaster, Mendiondo, Marcum, & Abner, 2008; Malmedal, Iversen & Kilvik, 2014; Teaster et al., 2007; Teaster & Roberto, 2004; Teaster, Roberto, Duke, & Kim, 2001; Teaster & Roberto, 2004). This finding is not surprising since the older a person is, the more likely that person is to require residential care and to experience physical and/or cognitive impairments. Under this assumption, then, we expect there to be a higher proportion of young-old individuals living in community-dwellings, and more old-old individuals to be living in residential institutions.

3.3 Location of Residence / Living Arrangement

As previously discussed, where a victim resides has implications for who is assaulted and by whom (Baker, Sugar, & Eckert, 2009; Del Bove et al., 2005; Jeary, 2004; Roberto & Teaster, 2005). Much of the literature on violence against older persons tends to emphasize older women's increased level of risk more broadly if they live with a spouse or another person in general (O'Keefe et al, 2007; Pillemer & Finkelhor, 1988; Lach et al., 1997; Naughton et al., 2010; Shiamberg & Gans, 2000) whereas other studies have found that older women who live alone have

a higher risk of sexual violence compared to their younger counterparts (Del Bove et al., 2005). Still others have found that living alone or in complex households (e.g. sharing with adult children or other extended family) was associated with a higher prevalence of abuse in general (Conroy, 2017; Naughton, Drennan, Lyons & Lafferty, 2013).

3.3.1 Community Residing

Whether victims reside alone or with another person, much of the sexual violence, domestic violence, and elder abuse research demonstrates that victimization occurs most often in the victim's home (Ball & Fowler, 2008; Bows, 2017; Del Bove et al., 2005; Grant & Benedet, 2012; Muram, Miller & Cutler, 1992; Pinto et al., 2014). Even compared to younger victims of sexual violence, older victims are more likely to be sexually assaulted in their homes while younger victims are more likely to be sexually assaulted somewhere else (Jones et al., 2009; Muram, Miller & Cutler, 1992; Del Bove et al., 2005). For instance, using data from a Sexual Assault Care Centre (SACC) in an Ontario city in Canada over a 10-year period (1992-2002), Del Bove and colleagues (2005) found that older victims (55-87 years) were significantly more likely to be assaulted in their own homes compared to middle-aged female victims (31-54 years) who were more likely to be assaulted in the perpetrators' home, and the youngest victims (age 15-30 years) who were significantly more likely to be assaulted in a vehicle. Research on victims of sexual violence in the US shows similar trends. Jones and colleagues (2009) and Muram and colleagues (1992) found that, among samples of victims of sexual violence, older women were most often sexually

assaulted in their home (72%-74%), compared to a much smaller proportion of younger victims who reported being sexually assaulted in their homes (19% - 46%). In these studies, most younger victims were assaulted in areas outside of their homes, including outside in public (7% - 38%), in another person's home (e.g. perpetrator or another friend's) (8%-25%), or in a vehicle (13%-17%).

Routine Activities Theory is helpful in understanding and explaining these age-related differences in risk for location of sexual assault (Payne, 2010). This theory posits that crime occurs with the convergence of three elements: 1) a motivated offender; 2) a suitable target; and 3) the absence of capable guardians (Cohen & Felson, 1979). The latter two elements have the most relevance in understanding victim risk. For instance, older women are more likely than younger women to reside alone and spend more daily time participating in passive activities such as watching television, listening to music, reading, or sleeping, compared to active activities that are more likely to occur outside of the home (Arriagada, 2018; Conroy, 2017). These findings collectively emphasize older women's level of risk stems from the fact that they are a suitable target with no capable guardians in their own homes, compared to younger women who are more likely to live with others and to engage in activities outside of the home (61% vs 28%) (Brennan, 2012; Safarik et al., 2002).

Older victims of sexual abuse typically know their offenders (Burgess & Phillips, 2006; Baker, Sugar, & Eckert, 2009; Cook-Daniels & Munson, 2010; Nosek, Hughes, Taylor, & Taylor, 2006). However, sexual abuse of older adults by strangers does occur. Utilizing a sample of women aged 50 years and older (N=198) who presented for a sexual assault exam, Baker and colleagues

(2009) found that stranger sexual assault accounted for almost one-quarter (24%) of victims who resided in their own homes, 20 percent of victims who were homeless, and 14 percent of victims who resided in residential care facilities. These proportions are much lower than the proportion of older women victimized by an acquaintance or friend across all three locations: 44 percent of victims who resided in their own homes, 16 percent of victims who resided in residential care settings, and 45 percent of victims who were homeless.

While the most frequent location for strangers to perpetrate sexual assaults on older persons is within the privacy of the victim's home, older adults who were victimized in their homes were most likely to report being assaulted by an acquaintance or a friend (Baker, Sugar, & Eckert, 2009) or a family member (Roberto & Teaster, 2005), not a stranger. Nevertheless, case law examples from Canada also disproportionally highlight stranger-perpetrated sexual violence against older adults (Grant & Benedet, 2016). However, when referring to stranger-perpetrated sexual homicide against older women, Safarik and colleagues (2002) report a 'grey area' between what can be considered a stranger and an acquaintance because few actual incidents occurred by complete strangers. While there were not clear pre-existing relationships, offenders tended to have some marginal contact with, or at least knowledge of their victims (e.g. offender may have performed services for the victim in the past; the offender and victim may share similar routine activities such as sharing a bus stop, or frequenting the same shopping areas), and, although not implying a prior relationship, the offender knew of the victim, where the victim lived (suitable target), and

perceived her to be alone and vulnerable (i.e. absence of capable guardians) (Safarik et al., 2002, p. 515).

Sexual abuse perpetrated by family members constitutes another form of sexual violence experienced by older adults residing in the community. Older victims of incestuous abuse are often mothers who are abused primarily by their middle-aged, unmarried, un(der-) employed sons (Crichton et al., 1999; Ramsey-Klawsnik, 2003). Sons who sexually abuse their older mothers often also have social impairments, substance abuse and/or mental health issues and are typically financially dependent upon their mothers (Ramsey-Klawsnik, 2003; Shiamberg & Gans, 2000). Sexual abuse perpetrated by other relatives, such as sons-in-law, grandchildren, siblings, and nephews, have also been reported in the literature, and typically also occur in the victim's home, a home that is frequently shared with these abusive relatives and who are often in a care-giver role to the victim (Chihowski & Hughes, 2008; Ramsey-Klawsnik, 2003; Roberto & Teaster, 2005).

Intimate partner violence, or sexual abuse of an older adult perpetrated by a spouse/partner, has been identified as a type of sexual mistreatment among older adults in the community (Bows, 2017; Dauvergne, 2003; Ramsey-Klawsnik, 1998; Zink & Fisher, 2006). Combined with physical violence, approximately one percent of older Canadians reported experiencing physical/sexual violence at the hands of an intimate partner (Brennan, 2012; Dauvergne, 2003; Poole & Rietschlin, 2012). Perpetrators of sexual violence within the context of an intimate relationship are overwhelmingly male and typically similar in age to their victims. In contrast, other perpetrators of sexual abuse of older persons are typically significantly younger than their victims (Crichton et

al., 1999). An analysis of Canadian data on family violence (not restricted to sexual abuse) against older adults found that, in general, adult children and spouses were the typical perpetrators of abuse in 71 percent of victimizations (Dauvergne, 2003). Perpetrators tended to vary by gender of the victim with older men being victimized most often by their adult children (43%) and older women equally likely to be victimized by their adult children (37%) and their spouses (36%) (Dauvergne, 2003). However, in examining potential gender differences among perpetrators and types of abuse, another Canadian study found that, independent of whether the perpetrator was an adult child or a spouse, they were most often male and the victim most often female (Crichton et al., 1999).

In summary, like other forms of interpersonal violence, familial and spousal sexual abuse of an older victim is overwhelmingly a problem of male violence towards women and rooted in power and control (Brandl, 2000; Ramsey-Klawsnik, 2003). This dynamic is especially problematic given the shared reliance that older victims and perpetrators of familial violence have on each other (Ramsey-Klawsnik, 2003). Victims and perpetrators are often dependent upon each other, socially, financially, and/or for daily assistance and practical help or care, further complicating the relationship between victim and perpetrator (Crichton et al, 1999; Godkin, Wolf, & Pillemer, 1989).

3.3.2 Institutional or Residential Care Facility Residence

Although most often assaulted in their homes, sexual abuse of older adults also occurs in residential care facilities (Jeary, 2004; Fileborn, 2016; Teaster et al., 2011; Bows, 2017; Roberto

& Teaster, 2005). In a residential care setting, older persons become victims of sexual violence at the hands of caregivers and other residents (Baker, Sugar & Eckert, 2009; Burgess et al., 2000; Jeary, 2004; Payne, 2010; Roberto & Teaster, 2005) and, in most cases, there is an abuse of power (Baker, Sugar & Eckert, 2009). Given the general climate and dynamics in care facilities, coupled with the likelihood that older residents of care facilities have mental health or other cognitive impairments (Jones et al., 2009; Roberto & Teaster, 2005), violence can be perpetrated with 'relative impunity' (Clark & Fileborn, 2011; Dowse, Soldatic, Spangaro, & van Toorn, 2016).

For instance, in a UK-based study of 52 cases of sexual violence against older adults, Jeary (2004) found that one-third of the cases occurred in residential care facilities. Similarly, in the US, Baker and colleagues (2009) found that, among almost 200 cases of older adult sexual violence victims who came to an emergency department for sexual assault services, one-quarter of the victims resided in institutional settings. There were no significant differences in rates of self-referral by living arrangement, as 80 percent of all victims were self-referrals to the hospital and the remaining 20 percent were referred by others.

Elder abuse and neglect in care facilities has been identified as a primary health issue and concern in Canada and globally (Conner et al., 2011; McDonald & Collins, 2000). However, few studies examining sexual violence against older adults use samples or data from care facilities, instead often relying on what little information comes to the attention of the police or other adult protective authorities (Fileborn, 2016; Grant & Benedet, 2016). While this is likely due to the

inability to access confidential samples or data from care facilities, the outcome is that little is known about the experiences of sexual violence by these victims (Bows, 2017).

In summary, key differences in the sexual violence of older victims based on location of residence include distinctions in victim, perpetrator and even assault characteristics (Baker, Sugar, & Eckert, 2009; Del Bove et al., 2005). Perpetrators of sexual violence against community-residing older victims tend to be strangers, family members, friends, or other acquaintances whereas perpetrators of sexual violence against older adults residing in residential care facilities are primarily staff members or other residents (Ahmad & Lachs, 2002; Baker et al., 2009; Roberto & Teaster, 2005). While we have limited knowledge of victims of sexual violence in care facilities, as noted earlier, we know that residents in care facilities have a higher likelihood of physical and/or mental impairments and limitations (Baker, Sugar, & Eckert, 2009), an issue we turn to next.

3.4 Mental/Cognitive and/or Physical Limitations

Poor physical and/or mental health as well as physical and/or mental disabilities have been associated with a higher risk of sexual victimization and abuse against older adults than those without limitations (Baker et al., 2009; Bows, 2017; Brownridge, 2006; Brozowski &Hall, 2010; Conroy & Cotter, 2017; Del Bove et al., 2005; Dowse, Soldatic, Spangaro, & van Toorn, 2016; Iverson, Kilvik, & Malmedal, 2015; Soares et al., 2010). Diminishing physical and mental health make older persons particularly vulnerable to abuse, especially when personal assistance is routinely required (Anetzberger, 2012; Baker et al., 2009; Chihowski & Hughes, 2008; Ramsey-

Klawsnik, 2003). The relationship between physical disabilities and impairments to sexual violence in older adults is an area that has received little attention in the literature. While some researchers find elevated instances of different types of abuse more generally among those with limitations (Cohen et al., 2005; Poole & Rietschlin, 2012; Schrottle & Glammeier, 2013), other researchers have found no significant differences in victimization rates based on physical disability status (Del Bove et al., 2005; Young, Nosek, Howland, Chanpong & Rintala, 1997). For instance, in their comparative study of women aged 18-65 years with and without physical disabilities in the United States, Young and colleagues (1997) found no significant differences in prevalence of sexual abuse: 39 percent of those with physical disabilities and 37 percent of those without physical disabilities reported sexual abuse. However, differences based on physical disability were found when examining the duration of abuse: women with physical disabilities experienced abuse over a longer duration than those without physical disabilities (Young et al., 1997). Limiting these findings, however, is that results were not analysed by age. Although Young and colleagues (1997) reported that on average those with disabilities were older than those without, the sample combined all victims between the ages of 18 and 65 years, severely restricting any conclusions based on age and disability status combined.

In Canada, research among female victims of sexual violence reported no age differences in physical disabilities among younger, middle, and older adults (Del Bove et al., 2005). However, a population-based community analysis of the 1999 Canadian General Social Survey found that, not only were older Canadians more likely to report having activity limitations such as a physical

or mental limitations compared to younger Canadians but, among women reporting contact with a current or former partner in the last five years, prevalence rates of sexual abuse were significantly higher among those with activity limitations, compared to women without activity limitations (3.5% and 3.6% compared to 1.4%) (Cohen, et al., 2005). However, like the study by Young and colleagues (1997), the Canadian analysis by Cohen and colleagues (2005) combined all respondents aged 18 years of age and older.

Findings on the relationship between psychological or mental health and sexual violence victimization among older adults shows more consensus than research surrounding the role of physical disabilities. The intersection of mental health and elder abuse is a significant public health issue (Rosen, 2014). Sexual assaults of older women with psychiatric diagnoses are frequent in the Canadian, US, and international literatures (Cooney & Howard, 1995; Del Bove et al., 2005; Johannesen & LoGidice, 2013; Poole & Rietschlin, 2012). Estimates range from one in five to three in five older victims of sexual abuse having some type of cognitive of psychological impairment (Del Bove et al., 2005; Eckert, Sugar, & Fine, 2002; Rosen, 2014). For instance, among victims of sexual violence who attended a sexual assault crisis centre in an Ontario city, older victims were significantly more likely than younger- or middle-age victims to have a history of psychiatric illness such as schizophrenia, depression, or bipolar disorder and an additional 20 percent of the oldest victims also had a cognitive disability (Del Bove et al., 2005). Expanding the victimization to include elder abuse more broadly, Burgess (2006) analysed 285 cases of elder abuse in the US, demonstrating that over 60 percent of the victims had a dementia diagnosis which

underscores the increased vulnerability these older victims have to victimization including identifying and disclosing the experiences (Burgess, 2006b; Cannell et al., 2014; Del Bove et al., 2005).

Research shows that individuals with dementia, Alzheimer's, or other cognitive impairments are at an elevated risk for all types of abuse including sexual abuse, compared to those without such conditions (Cooney & Howard, 1995; Cooney, Howard, & Lawlor, 2006; Dong, Chen, & Simon, 2014; Greenlee, 2012; Shaimberg & Gans, 2000). For instance, in a nationally representative German study on violence against women with various disabilities (including sexual abuse) who reside in households and institutions (n=1,561), Schrottle and Glammeier (2013) found that prevalence rates of physical, sexual, and psychological violence were "alarmingly high among women with disabilities" (p. 239). Women with mental disabilities experienced forced sex by an intimate partner at a significantly higher rate than those who were not mentally disabled (13-20 % of disabled women compared to 4% of the general population). Moreover, compared to those who had other disabilities, those who were deaf and those with mental disabilities who were living in residential institutions were found to be the most likely groups to be affected by both physical and sexual abuse (Schrottle & Glammeier, 2013).

Sexual perpetrators prey on victims who are easy to overpower, unlikely to report the abuse, and will not be viewed as credible if they do report (Benedet & Grant, 2014). Therefore, it is no surprise that research suggests that older adults with impairments are more likely to experience abuse compared to those who are older with no impairments or disabilities (Poole &

Rietschlin, 2012). Exacerbating their vulnerability is that older adults with psychological or cognitive impairments may have difficultly identifying the experience as sexual abuse and be less likely or unable to effectively disclose the abuse if they do identify it as such (Cannell et al., 2014). Moreover, if the abuse is disclosed, victims with cognitive impairments are often reliant on others to bring the complaints of sexual abuse to the authorities (Benedet & Grant, 2014). Relying on others to report sexual abuse can be problematic, not only if caregivers are the abusers, but also because there is ambivalence regarding the sexuality of women with disabilities. The social construction of disabled women as asexual yet also promiscuous or oversexed at the same time (Benedet & Grant, 2014; Schrottle et al., 2014), coupled with ageism and the infantilization of women with disabilities, exacerbates the intersection of aging, disability, and gender, creating the climate whereby women are denied both sexual self-determination and protection or safety from violence as a result (Benedet & Grant, 2014).

3.5 Characteristics of Perpetrators

While we know sexual violence against older adults is gendered, both male and female sexual abusers of older adults have been reported in the research (Bows, 2017; Burgess et al. 2000; Jeary, 2004; Roberto & Teaster, 2007). However, as noted above, the research on female-perpetrated sexual violence against older adults is rare and primarily restricted to isolated case studies scattered throughout the literature. For instance, among 185 incidents of elder abuse (60 years of age and up) from the Elder Abuse Resource Centre in Winnipeg, Canada, Crichton and

colleagues (1999) found one-third more son perpetrators (N=31) than daughter perpetrators (N=19) and almost seven times the number of husband perpetrators (N = 43) compared to wife perpetrators (N = 7). It is important to note however, that this study included sexual abuse within the broader definition of elder abuse, so it is unknown how many of these perpetrators committed sexual abuse as the form of the elder abuse because only 47 of the 185 incidents were categorized as such. Case law in Canada also provides evidence of the gendered aspect of elder sexual assault, as 98% of cases of elder sexual assault involved female complainants (Grant & Benedet, 2016). Specific studies on elder sexual abuse in the US report similar trends. For example, Baker and colleagues (2009) identified 152 cases of male-perpetrated sexual assault of older victims, only three cases of female perpetration were identified. Also, among 15 known perpetrators of sexual assault of older adults in nursing homes, only one perpetrator was a female nursing aid (Burgess et al., 2000). Other studies describe, or mention, select case examples or instances of female-perpetrated sexual assault of older adults for illustrative purposes, but due to their scarcity, it is difficult to provide other statistics or proportional counts for female perpetrators (Chihowski & Hughes, 2008; Crichton et al., 1999; Jeary, 2004; Payne, 2010; Roberto & Teaster, 2005).

Despite some research on perpetrators of sexual violence, few studies focus specifically on those who victimize older persons (Bows, 2017; Groth, 1978; Muram et al., 1992; Pollock, 1988; Safarik et al., 2002). These perpetrators represent a distinct group of offenders, varying from offenders who target children or younger adults (Browne, Hines, & Tully, 2016; Pollock, 1988). For example, compared to perpetrators who target younger victims (e.g. children, young-adults, or

middle-aged adults), perpetrators who target older women tend to display more severe behaviours, motivated by rage, anger, sadistic intent and/or a desire to be in control (Ball, 2005; Jeary, 2005; Pollock, 1988; Shaimberg & Gains, 2000). They are more likely to engage in brutal violence involving a weapon, resulting in injury, or death (Burgess, 2006; Ball, Snowden & Strickland, 1992; Ball, 2005; Browne, Hines & Tully, 2016; NCALL, 2010; Pollock, 1988). Canadian researchers support this finding: approximately 20 percent of cases of sexual violence against an older woman involved a dangerous offender application during prosecution and this proportion was noted to be much higher than the proportion of dangerous offender applications found in sexual assault prosecutions of younger victims (Grant & Benedet, 2016). Thus, like all sexual violence, it is not necessarily about sex or desire, but rather an act fueled by control, dominance, and possibly anger, that occurs in a sexual context (Burgess, 2006).

There is a lack of consistency in the literature on individual perpetrator characteristics in cases of sexual violence towards older adults. In a study of convicted sex offenders, Groth (1978) reported that perpetrators who victimized someone substantially older than themselves were most often white, single males, who had difficult childhoods and adolescence, came from unstable households, and showed a general lack of respect towards their mothers. In contrast, Pollock's (1988) case-control study of perpetrators of sexual violence of older women in a Canadian city, found no differences in socio-demographic characteristics, employment or marital status, psychiatric or criminal history, or childhood behavioural problems when comparing perpetrators who sexually abused younger and older victims. However, the common finding in these two

studies is that, compared to perpetrators who target younger victims, perpetrators of older victims of sexual assault were more likely to use brutality, excessive violence, and/or weapons (Groth, 1978; Pollock, 1988).

While this early research on perpetrators of sexual violence towards older adults is important, it is central to note these findings are limited by exceptionally small sample sizes of offenders. For example, Groth's (1978) study included only 20 perpetrators of sexual violence towards victims over 50 years and Pollock (1988) examined only five cases of sexual assault of victims over 60 years of age. Moreover, these studies examined those who perpetrated assaults largely on victims in their own homes thereby failing to account for potential differences in offenders across locations.

Recent studies are also limited by small sample sizes yet are instructive in identifying some of the common characteristics and potential motivations among offenders who perpetrate sexual violence against older persons (Ball et al., 1992; Cartwright & Moore, 1989; Collins & O'Connor, 2000). Examining 52 cases of sexual violence against older persons in England and Wales, Jeary (2005) reports that motivations for these sexual offences include financial gain, self-focus and countering sexual inadequacy, sexual gratification and sexual fantasies, power, control, and revenge towards either the specific victim, or other women, and a previous history of childhood abuse and victimization - all of which are consistent with the motivations identified both in earlier and more recent research (see for example; Burgess et al., 2007; Groth, 1978).

The brutality of sexual violence against older adults is further compounded when considering sexual homicide of older women. In their analysis of 128 closed cases of sexual homicide of women 60 years of age and older in the United States, Safarik and colleagues (2002) found that 44 percent of the perpetrators were white, 42 percent were black, and the remaining perpetrators were Hispanic or 'other', all ranging in age from 15 to 58 years. Fairly consistent across this group of offenders was that 90 percent had criminal records, 93 percent had a history of substance abuse, 93 percent had a high school education or less, and 70 percent were unemployed.

In summary, knowledge regarding perpetrators of sexual violence against older adults is limited. The vast majority of information is derived from case reports at police stations or other agencies (e.g. adult protective services in the US) and, therefore, it cannot be assumed that these cases are characteristic of all perpetrators because those who do not come to the attention of authorities may be quite different from those who do (Ball, 2005). Moreover, the few studies examining perpetrators of sexual violence against older adults are fraught with methodological shortcomings related to extremely small sample sizes (e.g. sample sizes range from as few as four perpetrators to just over 100 perpetrators), or highly-selective case studies, and lack a control group (Ball, 2005). Thus, conclusions should be made with caution.

3.6 Other Correlates

While the correlates presented above represent the most frequently reported in the literature, there are other correlates that, while less common, may still be worth examining in future research. These include race/ethnicity, marital status, income, and education of victims and perpetrators as well as available social supports for victims and previous victimization experiences.

3.6.1 Sociodemographic Characteristics: Few Canadian studies have considered the association between immigrant status or race/ethnicity and the experience of sexual abuse among older adults (Matsuoka, Guruge, Koehn, Beaulieu, & Ploeg, 2012). What we do know about sexual violence in Canada and race/ethnicity specifically, however, is that Indigenous women are disproportionately victims of sexual violence across the lifespan, including in older age (Brozowski & Hall, 2010; Conroy & Cotter, 2017; Grant & Benedet, 2016). Due to a wide variety of historical and cultural influences, including but not limited to historically discriminatory and marginalized treatment by, and fear of, and lack of trust in the CJS, the full extent of Aboriginal people's victimization is not fully reflected in official statistics (Hayman, 2011). For instance, most victims presenting at a sexual assault clinic in a Canadian city were white (Del Bove et al., 2005), highlighting a possible discrepancy in disclosure and help-seeking rates based on race/ethnicity, an issue we will return to below. Nevertheless, among Canadians 35 years of age and older, Aboriginal persons are approximately three times more likely than non-Aboriginal persons to experience violent victimization; a finding that is mirrored specifically for spousal violence, as Aboriginal Canadians experience spousal violence victimization at a rate three times higher than non-Aboriginal residents in Canada (Brzozowski, Tylor-Butts, & Johnson, 2006; Hayman, 2011).

As such, it is not unreasonable to infer that Aboriginal seniors will experience higher rates of victimization than their non-Aboriginal counterparts (Hayman, 2011), and this includes sexual violence victimization.

Additional considerations include the intersection of ethnicity and other variables such as physical/mental limitations and associated risk for sexual violence victimization. More specifically, Canadian research indicates that individuals who have activity limitations are more likely to experience sexual violence than those without limitations, and further, Indigenous women are more likely to report having activity limitations compared to non-Indigenous women (Cohen et al. 2005), emphasizing the importance of considering intersectionality or the way in which varying social identities intersect with aging to compound risk (See for example: Older Women's Dialogue Project).

Studies conducted in the United States show that older victims of sexual abuse are typically white compared to other race/ethnic groups (Bows, 2017; Burgess, 2006; Cannell et al., 2014) and this holds true for older victims of sexual homicide (Safarik et al., 2002). The disproportionate number of white victims of sexual violence in the United States could also be due to varying disclosure rates among victims from different cultural groups and/or culturally-specific definitions of sexual violence and abuse (Ahmad & Lachs, 2002; Enguidanos, Deliema, Aguilar, Lambrinos, & Wilber, 2014) because we know that it is not only white women who are victimized (Cook et al., 2013; Safarik et al., 2002).

There is a lack of consistent findings about the role played by marital status in determining risk of sexual abuse among older adults as well. While some studies report higher levels of general victimization, including sexual violence, among older adults who are divorced, widowed, or separated (Brennan, 2012; Brozowski & Hall, 2010; Cook et al., 2013), other researchers have found that older and married adults are more likely to experience all forms of abuse compared to older divorced/widowed adults (Shiamberg & Gans, 2000). For example, in a Canadian study of female victims at a sexual assault crisis centre, marital status was found to vary significantly by age of the victim. Younger victims were significantly more likely to be married at the time of the sexual assault, while the older victims (55 years and up) were significantly more likely to be widowed (Del Bove et al., 2005).

Other sociodemographic characteristics identified in some of the literature indicate that lower levels of income and education are also associated with higher levels of sexual violence among older adults (Bows, 2017; Brozowski & Hall, 2010; Cannell et al., 2014; Naughton et al., 2010; Soares et al., 2010), but existing research is limited, and conclusions are difficult to reach as a result.

3.6.2 Other Characteristics: In one Canadian study of younger and older victims of sexual violence, previous sexual victimization was found to be the strongest predictor of sexual assault among older adults (Del Bove et al. 2005) and this is consistent with other studies conducted in the United States and internationally that highlight previous traumatic events are related to abuse

in older adults (Aciemo et al., 2010; Schrottle & Glammeler, 2013). Also, of note, lower levels of social support were found to be associated with all types of abuse (Aciemo et al., 2010) and older victims of sexual violence were significantly less likely than younger victims to report having social support (Del Bove et al. 2005), providing further illustration of the heightened vulnerability for sexual abuse victimization among older persons.

4.0 SEXUAL ASSAULT OF OLDER ADULTS: IMPACTS, OUTCOMES & DISCLOSURE

Adverse health-related outcomes of sexual violence against older persons are some of most frequently discussed in the literature and justifiably so. The brutal nature of sexual violence against older women often results in severe trauma, further adding to the consequences and challenges experienced by older victims of sexual violence, especially those with impairments such as dementia (Burgess & Clements, 2006). The outcomes and impacts of sexual violence of older adults can be immediate, short-term, and/or long-term. While there may be some similarities in the aftermath of sexual assault experience(s) across victims of all ages, there are unique consequences specific to older women who have been sexually abused/assaulted (Eckert & Sugar, 2008; Fisher & Regan, 2006, NCALL, 2010). Health-related consequences of sexual violence of older persons take a toll on victims (Fisher & Regan, 2006; Grant & Benedet, 2016), and include both physical and psychological injuries and impacts as discussed below.

4.1 Health Related Impacts: Physical Injuries

Physical impacts of sexual abuse or assault of older adults include aches, pains, cuts, bruises, bite marks, headaches, contusions, lacerations, fractures, internal injuries, genital injuries, sexually-transmitted infections (STIs), declines in physical health, and even death (Bows, 2017; Biggs, Phillipson, & Kingston, 1995; Cook et al. 2013; Del Bove et al., 2005; NCALL, 2010; Safarik et al., 2002; Speck et al., 2013). Although physical injuries are not always evident following sexual violence in older victims (Burgess, 2006; Cartwright & Moore, 1989; Tyra, 1993), compared to younger women, older postmenopausal women who have been sexually assaulted tend to be more likely to experience genital trauma and injuries and as a result are more predisposed to contracting STI's (Cartwright, 1987; Eckert & Sugar, 2008; Del Bove et al., 2005; Jones et al., 2009; Muram, Miller & Cutler, 1992; NCALL, 2010; Payne, 2000). For instance, Muram and colleagues (1992) assessed medical records of sexual assault victims who attended a sexual assault clinic in Tennessee and found that older victims of sexual violence (55 and up) were more likely to experience injury compared to younger victims (18-45 years) (51% vs 13%) and these injuries were so severe that almost one-third of victims required surgical repair. While the more brutal and violent nature of sexual violence against older victims compared to younger victims has been described in the literature (Jeary, 2004; Groth, 1978), these case-control studies suggest that, compared to younger victims, the increased rates of (genital) injuries are likely a result of hormonal and physiological changes associated with aging (Jones et al., 2009; Muram, Miller & Cutler, 1992). This is consistent with the findings of other researchers who have also linked older women's increased risk of injuries following sexual violence to their increased

vulnerabilities and propensities to injury because of increasing age and subsequent physiological and biological hormonal changes (Cartwright, 1987; Eckert & Sugar, 2008). Therefore, as a function of the intersection of age and gender, older women are likely to experience more severe injuries compared to younger women.

While there is a lack of longitudinal research examining the impacts of sexual violence among older adults, in women, a history of sexual assault with associated with increased risk of arthritis and breast cancer, and for men, a history of sexual assault was associated with an increased risk for thyroid disease (Stein & Barrett-Conner, 2000), emphasizing the potential for long-term impacts of sexual victimization. In addition to a higher frequency of injuries, older victims of sexual violence are also at increased risk for mortality (Cook, 2013; Dong & Simon, 2013; Jeary, 2004) because they are more likely to be killed in comparison to other victims of similar crimes (Davis & Brody, 1979; Pollock, 1988), a finding influenced by the fact that older people are at a higher risk due to physical frailty, weakness, age-related physiological changes, and an inability to recognize or report abuse (Kleinschmidt, 1997; Pearsall, 2005).

4.2 Health Related Impacts: Psychological Outcomes

Psychological impacts and consequences of sexual violence of older people are commonly reported in the literature. These impacts include fear, anxiety, depression, agitation, stress, anger, and difficulty with interpersonal relations (Gutek & Koss, 1993; Jeary, 2004; Pryor, 1995; Schneider et al., 1997). Reviewing a convenience sample of 284 cases of sexual abuse among older

adults, Jeary (2004) found that the most frequently observed and reported symptoms were numbness and physiologic upset, including negative changes to sleep, appetite, and mood. Further compounding the psychological impacts of sexual violence are the social, cultural, and generational values and beliefs that are held by older victims of sexual violence. For instance, victims may feel shame, guilt, disgrace or humiliation (Ball, Snowden & Strickland, 1992; Jeary, 2005; Sev'er, 2009) which may not only impact the recognition of sexual violence, but also the likelihood to disclose to, or seek help from others. An analysis of the 2014 Canadian General Social Survey on Victimization reports that one in four victims of sexual assault (18 years and older) has difficulty carrying out daily activities and one in six victims have multiple long-term emotional disturbances, possibly characteristic of post-traumatic stress disorder (PTSD) (Conroy & Cotter, 2017). While this previous study was not restricted to older victims, the findings resonate with other researchers, who have found that the impacts of physical and sexual assault on older adults included long-term mood and anxiety disorders as well as PTSD (Cook et al., 2013). Taken together, physical and psychological impacts of sexual abuse can be especially traumatic and life-changing for older women (Jeary, 2005) who may face additional barriers to disclosure and recovery, particularly if they have cognitive impairments such as dementia (Burgess & Clements, 2006; Fileborn, 2016; Schrottle & Glammeier, 2013).

4.3 Disclosure in the Aftermath of Sexual Violence: What do Older Victims Typically Do?

The consequences of sexual violence in older age do not end at the physical and psychological impacts. Not only do victims have to cope with injuries, but they must also consider issues relating to disclosure and help-seeking behaviour. The statistics regarding elder abuse prevalence and incidence are not only limited due to substantial methodological and sampling issues but are also inadequate due to significant under-reporting as discussed at the outset (Burgess et al., 2008; Cohen et al., 2007; Grant & Benedet, 2016; Fileborn, 2016; Ramsey-Klawsnik, 1993). There are a number of reasons why older victims of sexual violence do not report their experiences of victimization, and while some of these reasons mirror those of younger victims, the motivations behind non-disclosure among older persons, and older women specifically, are compounded by various generational cultural and social norms and histories surrounding privacy, family affairs, and what constitutes sexual assault, sexual abuse, or sexual violence (Burgess, Ramsey-Klawsnik, & Gregorian, 2008; Crichton et al., 1999; Fileborn, 2016; Grant & Benedet, 2016; Ploeg et al., 2013; Poole & Rietschlin, 2012).

Differential rates of reporting among younger and older victims of sexual violence may be a result of reporting bias and a lack of understanding about the terminology and definitions surrounding sexual abuse and violence (Cook et al., 2011; Crockett et al., 2015; Lobell, 2006; Ploeg et al., 2013; Stockl, Watts, & Penhale, 2012), a finding further confounded by differences in cultural understandings and conceptions of abuse and violence (Ploeg et al., 2013). For instance, in a Canadian study on perceptions of elder abuse among older marginalized persons (e.g. those identifying as Aboriginal, immigrant, refugee and lesbian), definitional variations and emphasis

on what constitutes elder abuse were evident across the different groups. Most notable however, was that in their discussions of elder abuse, Aboriginal participants, those identifying as lesbian, immigrants from countries in Europe, and Chinese speaking immigrants either completely denied awareness of sexual abuse, or only acknowledged sexual abuse as a component of elder abuse when prompted by the facilitator (Ploeg et al., 2013). Female refugees from Afghanistan on the other hand, focused on the continuation of culturally acceptable physical, emotional, and sexual spousal abuse into old age (Ploeg et al., 2013). These findings emphasize how different identity characteristics such as race/ethnicity, immigrant status and duration, and sexual orientation intersect with age to influence perceptions of elder abuse, providing additional evidence of the diversity among older Canadians, and thus the need to account for the intersection of factors when attempting to understanding, explain, and/or address elder sexual violence.

Generationally speaking, older women grew up within a social and legal climate surrounding sexuality and sexual violence where private matters were kept private, sex was considered a private matter, definitions of rape were very narrow, and rape within marriage was unheard of as it was the woman's duty to provide sexually for her husband. Because of these generational specificities, many older women fail to recognize their experiences as sexual abuse, further impacting disclosure rates (Brozowski & Hall, 2010; Crockett et al., 2015; Fileborn, 2016; Lobell, 2006). In fact, in their study of community-dwelling adults over 65 years of age in Ireland, Naughton and colleagues (2013) examined the relationship between awareness and disclosure of elder abuse to find that 20 percent of the sample were not familiar with the term 'elder abuse', and

many did not associate abusive behaviours in their lives with abuse. However, among the different types of elder abuse, the more serious types are more likely to be disclosed. For instance, among a sample of community residing elders aged 70 years and older who attended a major hospital in Israel, Cohen and colleagues (2007) found that direct disclosure of physical and sexual abuse was most common (compared to financial and psychological abuse as well as neglect), suggesting that older victims are more willing to disclose abuse when their victimization is more serious in nature. Moreover, given that older victims of sexual assault are more likely than younger victims to experience genital and other injuries (Eckert & Sugar, 2008; Jones et al., 2009; Muram, Miller & Cutler, 1992; Payne, 2000), it follows that recognition and acknowledgement by friends, family, and caregivers of older victims of sexual assault would be more likely when injuries are visible and present.

Disclosure rates and coping strategies of older persons are not well researched or understood in the literature (Bows, 2017). The limited research on reasons for non-disclosure indicates that older victims of sexual violence are often worried about feelings of credibility, blame, shame, or embarrassment (Bachman et al., 1998; Baker et al, 2009; Burgess, Ramsey-Klawsnik, & Gregorian, 2008; Crichton et al., 1999; Fileborn, 2016; Payne, 2000; Sev'er, 2009) as well as a fear that they will lose control or become powerless (Brandl et al., 2003; Johannesen & LoGiudice, 2013). With aging comes declines and changes to one's health and subsequent increases in dependency on others. This dependency creates vulnerabilities for older persons who, fearing damage to relationships with family or being institutionalized or moved to a less desirable

environment, may normalize or justify the abusive behaviours (Burgess & Morgenbesser, 2005; Cannell et al., 2014; Zink et al., 2006) and hesitate to disclose abuse or to leave an abusive marriage (Crockett et al., 2015; Fileborn, 2016; Johannesen & LoGiudice, 2013; Lobell, 2006; Payne, 2002; Shiamberg & Gans, 2000). In short, in their mind, their victimization may not be as bad as the unknown – what will happen if they disclose or report to others. The reluctance to disclose abuse due to the fear of being placed in a residential setting are not unwarranted. Researchers have found that violent crime victimization (in general and not specific to sexual victimization) among older adults actually increases the risk of being placed in a nursing home by odds of two to one, a finding that was stronger than the risk associated with other factors such as the presence of impairments and lack of social support typically thought to influence nursing home placement (Lachs, Bachman, Williams, Kossack, Bove, & O'Leary, 2006).

In fact, in cases where the perpetrator had a previous relationship with the victim, victims are more likely to delay help-seeking (Jones, Alexander, Wynn, Rossman, & Dunnuck, 2009; Sev'er, 2009). In cases of sexual abuse by a spouse, attachment to one's abuser represents a substantial limitation and barrier to leaving and disclosing the abuse (Bows, 2017). While attachment to and reliance (especially financial) on an abusive spouse is not a unique barrier to disclosure and help-seeking among older adults specifically, what is unique is that, for older victims, the options for starting over are diminished. Separation can be particularly detrimental, especially when there are health problems involved and perpetrators are responsible for their victim's care (Bows, 2017; Fileborn, 2016; Ramsey-Klawsnik, 2003). Moreover, the stigma and

shame when abusers are intimately related to victims may lead to additional impediments and barriers to help seeking or disclosing instances of familial perpetrated sexual abuse (Sev'er, 2009).

Additional impediments to disclosure or help-seeking among older victims of sexual violence, specifically for those who reside in the community, include the lack of victim services available for older persons, especially those with mental or physical health impairments and diverse sexualities, and the belief that shelters or crisis centres are for younger or parenting women (Crocket et al., 2015**;** Kirkman, Kenny, & Fox, 2013). Research findings, although limited, reveal that older victims have difficulty initiating discussions about abuse with their health care providers (Zink et al, 2004), may fail to recognize their experiences as abuse (Naughton et al., 2013), and may not be believed when they do disclose their victimization, further emphasizing how the particular needs of older women survivors of sexual violence are not being addressed (Ondeck, 2002; Scriver, Amanda Phelan, Mears, & Wallace, 2013).

While there are numerous barriers to disclosure among older victims more broadly, victims with dementia and other cognitive impairments experience heightened vulnerability as they may not be able to effectively verbalize their abuse experiences and may also have substantial difficulty with recall and memory. Victims with dementia or other cognitive delays may be confused more easily, less likely to communicate their experiences, or less likely to be believed if they do try to disclose (Burgess et al., 2000; Eckert & Sugar, 2008; Fileborn, 2016; Groth, 1978; Jones & Powell, 2006; Payne, 2010; Teaster et al., 2015). In their examination of 284 forensic cases of elder sexual abuse in the United States, Burgess and Phillips (2006) reported that, although one-third of the

victims disclosed the abuse, 62 percent of those who did not suffer from dementia self-reported their sexual abuse victimization compared to only 13 percent of those with dementia. The lower rates of self-reporting for those with dementia or other cognitive limitations underscores the vulnerability of older persons residing in long-term care facilities, or similarly those who, because of their impairments, are reliant and dependent upon others (Fileborn, 2016; Iversen, Kilvik, & Malmedal, 2015). Nevertheless, victims with dementia do tend to disclose their victimization experiences through behavioural cues and indirect statements such as showing agitation or fear when the perpetrator is around or showing signs of distress during personal care and grooming (Burgess & Phillips, 2006; Burgess & Clements, 2006; Fileborn, 2016). But, since many people do not view older persons as likely victims of sexual violence, family members and professionals fail to look for signs of sexual abuse and, thus, may not effectively recognize these signs and disclosure methods, especially among older persons with cognitive impairments such as dementia (Fileborn, 2016; Pearsall, 2005; Simmelink, 1996).

Nevertheless, once abuse is suspected, disclosed, or witnessed, instances of elder sexual violence do not all have the same outcome. Informal institutional responses and formal justice responses have been identified in the literature – an area we turn to next.

5.0 SEXUAL VIOLENCE AGAINST OLDER ADULTS: INSTITUTIONAL & CRIMINAL JUSTICE RESPONSES

More than 90 percent of Canadians identified that addressing elder abuse should be the most important intervention for government when it comes to the aging population (Government of Canada, 2015; Yon et al., 2017). However, information on responses to the sexual violence of older adults in Canada is overwhelmingly absent with only a few exceptions (see: Grant & Benedet, 2016; McDonald, 2011). Responses to the sexual assault of older adults tend to be grouped into institutional responses (e.g. responses in long-term care facilities) and criminal justice responses. Additionally, in the United States, some studies focus on cases of elder abuse specifically reported to and investigated by Adult Protective Services (APS), a social service agency designed to protect vulnerable adults by investigating reported cases of suspected abuse and neglect (see for example; Burgess, Ramsey-Klawsnik & Gregorian, 2008). Institutional responses are primarily relevant for older victims of sexual assault residing in care facilities while criminal justice responses appear to be relevant for both community-residing and care facility-residing adults. Pathways to institutional responses are usually direct, stemming from self-reporting of the victimization to facility staff or family members who subsequently report the abuse to staff, and third-party reporting or disclosure by witnesses such as other staff or residents. Once the institution is made aware of suspected or substantiated abuse, responses vary, and these may or may not lead to CJS reporting. Police, or local law enforcement represent the gatekeepers to, or the first CJS response in cases of sexual violence. However, we know that victims face several impediments when disclosing their victimization, and therefore abuse that makes it to the attention of the police is only the tip of the iceberg (Dyer & Rowe, 1999). Police are made aware of elder

sexual abuse through various avenues including direct self-reporting of one's victimization to the police, reporting to a rape crisis centre, a physician, or a hospital, or third-party reporting by witnesses. When the elder reports at a rape crisis centre, to a physician, or at the hospital they are typically offered the choice to self report their victimization to the police, and sometimes a report is filed on behalf of the victim, often when cognitive impairments are evident, or in the case of third party witness and subsequent reporting (Burgess, Ramsey-Klawsnik, & Gregorian, 2008).

The following section will discuss key findings from the literature on responses to sexual violence against older adults. While research findings from studies in the United States are incorporated, the focus will be on the institutional and criminal justice responses specific to Canada, where such research is available.

5.1 Institutional Responses to Sexual Assault Against Older Adults

Among health care workers, reporting is the most common yet contentious form of intervention when responding to elder abuse (Bonnie & Wallace, 2003). Various factors influence the motivations of physicians and other health care workers for reporting abuse to authorities such as the police, or in the US, to adult protection services (APS). For example, health care workers may lack appropriate knowledge and familiarity with reporting policies and laws, they may lack of confidence in their ability to properly identify abuse, especially in the context of pre-existing or spousal relationships, and they may feel ambivalence about offending patients by questioning their ability to provide consent or by violating doctor-patient trust, privacy, or confidentiality (Burgess,

2006; Chihowski & Hughes, 2008; Hirsch et al., 1999). This uncertainty and ambivalence towards recognizing and reporting potential instances of elder sexual abuse is further complicated by the notion that legislative responses to elder abuse in Canada fail to respect individual independence while promoting ageism by assuming older persons are incapable of help-seeking (Dauvergne, 2003). Health care workers are faced with a potential infringement of human rights in cases of forced intervention (Harbison, 1999). Thus, health care workers must balance and weigh out whether an individual is able to give meaningful sexual consent with the sexual rights of older persons (Clark & Fileborn, 2011; Fileborn, 2016).

The literature analyzing sexual violence among older residents underscores a dire need for improvement in the way cases of sexual abuse are handled within institutional contexts. Recognizing sexual assault within care facilities is one of the most challenging types of assault to investigate, and although most facilities respond appropriately (Ramsey-Klawsnik & Teaster, 2012), one study found that in about 40 percent of cases, care facilities either failed to prevent or respond to sexual abuse in appropriate ways (Ramsey-Klawsnik et al., 2008), often leading to. delayed reporting (Burgess, 2006; Chihowski & Hughes, 2008; Smith et al., 2017), difficulty assessing intentional versus accidental injuries or recognizing cues about sexual abuse (Burgess, 2006; Jeary, 2004), complete failure to report abuse to authorities such as the police, lack of documentation of evidence (Malbedal, Iversen & Kilvik, 2014), the destroying of evidence (Burgess, Ramsey-Klawsnik & Gregorian, 2008; Chihowski & Hughes, 2008), and staff minimizing, denying, or ignoring, the abuse (Burgess, 2006; Malmedal, Iversen & Kilvik, 2014;

Smith et al., 2017). All this often occurs alongside an absence of institutional policies, procedures, and/or regulations on how to proceed in cases of sexual abuse of older persons (Filborn, 2016; Smith et al., 2017). These examples point to the numerous barriers in acknowledging and reporting the sexual assault of older adults to the police or other authorities (Dauvergne, 2003; Malmedal, Iversen & Kilvik, 2014; Zink & Fisher, 2006).

The motivations or reasons behind the delay in, or lack of, responses are unknown, yet consequences of delayed institutional response to sexual assault of older adults have been documented and tend to be related to a lack or loss of evidence (Burgess, 2006; Chihowski & Hughes, 2008; Smith et al., 2017). When responses are delayed, whether for preservation of facility reputation (Chihowski & Hughes, 2008), uncertainty regarding identification of abuse, or determining whether there was consent between residents or an older couple for example (Grant & Benedet, 2016), the potential loss of biological evidence and memory or recall for the older victim is intensified and negatively impacts the progression of the case, placing the victim at increased vulnerability for continued abuse and revictimization (Burgess, 2006; Chihowski & Hughes, 2008; Tyra, 1993). These findings suggest that delays in responding to sexual violence further contribute to issues with accuracy of estimates of prevalence and incidence rates.

Often however, delaying or refusing to formally report cases occurs based on the discretion of administrators or employees of residential institutions, where many cases are addressed informally or internally (Fileborn, 2016; Grant & Benedet, 2016). Given the high rates of dementia and other impairments among older adults who reside in residential care facilities (Smith et al.,

2017), police and medical rape examinations or criminal justice involvement may be viewed as futile or too traumatic for the victim (and perpetrator in cases of resident-resident abuse) (Burgess, Ramsey-Klawsnik, Gregorian, 2008; Grant & Benedet, 2016), especially considering that despite age-related physiological changes, protocols for sexual assault examinations do not vary based on age (Thomas et al., 2014), making these examinations physically challenging for both victims and physicians (Smith et al., 2017). These beliefs may shed light on findings from a sample of victims presenting to a Canadian hospital-based sexual assault care centre, where only approximately 50 percent of the oldest victims (55-87 years) received a forensic kit, a proportion that is lower than the 60% of mid-age (31-54 years) victims, and 63% of younger victims (aged 15-30 years) in this study who received a forensic kit (Del Bove et al., 2005). Findings from US research is similar. In cases of sexual violence victimization among older adults in the US, researchers found that less than half of the victims were referred for a rape exam, and only about one-third of the cases involved collection of evidence such as clothing, underwear, or an evidence kit (Burgess, Ramsey-Klawsnik, & Gregorian, 2008). These findings are also more pronounced for victims residing in residential care homes. In comparison to older community-residing sexual assault victims, female nursing home victims were less likely to have a rape kit/examination, and were less likely to be tested for STIs and to be examined for physical trauma (Burgess, Hanrahan, & Baker, 2005). However, despite the lack of formal action being taken in the form of evidence collection or forensic exams, cases of elder sexual abuse in long-term care facilities are often dealt with internally via informal institutional responses.

Informal institutional responses in cases of sexual violence of older persons by institution staff include employee termination, resignation to work at another facility, and in some instances, the addition of an abusive employee to an abuse registry (Teaster et al., 2007; Ramsey-Klawsnik et al., 2008). In cases of resident-to-resident abuse, victims may be relocated within or across facilities, perpetrators may be required to have no contact with the victim, they may be placed under increased supervision and/or receive psychiatric treatment, or they be moved to a different facility (Fileborn, 2016; Smith et al., 2017; Ramsey-Klawsnik et al., 2008; Roberto & Teaster, 2005; Teaster & Roberto, 2004). All these responses have the potential to increase stress and anxiety in an already demanding context. For instance, when staff are fired or moved, facilities may be understaffed temporarily, additional disruptions in the daily lives of residents may emerge; and in cases of resident-to-resident abuse, short notice for the relocation of resident victims or perpetrators may cause added burdens not only for residents and staff who may have difficulty finding another facility that has space for new residents, but also for their families, who often put immense time and effort into deciding on a residential facility for their loved one, and who are likely to feel blame and responsibility for their loved one being assaulted especially if they were the ones who put them in the facility (Burgess, n.d).

Due to the complexities associated with and the variety (or lack thereof) of responses, systematic documentation of the characteristics of sexual violence against elder persons is further convoluted. Nevertheless, while failure to formally report sexual assault against an older adult may seem neglectful at face value, as Fileborn (2016) has indicated, it is important to remember that

"the appropriate responses to incidents of sexual assault against older women are likely to vary according to the specifics of the case at hand and do not always necessitate a 'formal' justice response" (p. 6). When responding to cases of sexual abuse among older adults, the primary goal should be to stop further abuse and, to do this, informal responses in the institutional settings may be most appropriate.

5.2 Criminal Justice System (CJS) Responses to Sexual Assault Against Older Adults

As discussed, not only is knowledge limited with respect to the scope or nature of elder abuse in Canada, including sexual abuse (McDonald, 2011), but family violence and criminal laws in Canada are not used consistently in cases of abuse of older adults, as the "legal and policy framework is patchy" (Tyyska et al., 2012, p. 63). There is also limited inclusion of sexual assault of older adults in case law (Grant & Benedet, 2016). Consequently, one of the most prominent gaps in our knowledge about sexual assault of older women involves understanding the way in which the justice system responds (Grant & Benedet, 2016; Payne, 2010; Fileborn, 2016). While there is some literature that draws on studies conducted in the United States (US), given the differences in laws and policies, we need to be cautious when applying these results directly to Canada, but the trends can at least be "instructive" (Grant & Benedet, 2016, p. 61).

Findings from research in the US tend to suggest that CJS responses to sexual violence perpetrated against older adults vary based on victim's age, location of the assault, and the nature of the victim-perpetrator relationship. In general, older victims of sexual violence are less likely

than younger victims of sexual violence to have their cases proceed through the CJS. For instance, in their analysis of 79 substantiated APS cases of sexual violence, Roberto & Teaster (2005) found that compared to younger women (age 18 to 39 years), older women (age 60- 79) and the oldest women (80+ years) were much less likely to have their cases prosecuted in the CJS (16 % vs. 8% and 3%). However, this could be related to the fact that compared to younger victims of sexual violence, older victims are more likely to have cognitive impairments impeding prosecution (Roberto & Teaster, 2005), are more likely to reside in care facilities, are less likely to reside in the community, and are more likely to be assaulted by another resident in a care facility (Roberto & Teaster, 2005), or someone they know (DelBove et al., 2005) – characteristics typically associated with lower levels of disclosure and a lower likelihood of intervention. However, it should be noted that while older sexual assault victims face a myriad of obstacles and impediments in the aftermath of sexual violence, they often tend to "escape the negative effects of rape culture – at least in the legal context" (Grant & Benedet, 2016). Compared to younger women, older women are often not even recognized as sexual subjects (Sev'er, 2009; Fileborn, 2016), and although at a rate much lower than younger victims, when their cases do progress through the CJS it is rare that consent is even questioned or contested, and there are typically no references to the women's past sexual history – tactics that are frequently used to undermine the credibility of younger victims of sexual violence (Grant & Benedet, 2016).

In a comparison of elder sexual abuse cases (n=127) and elder physical abuse cases (n=314) in the US, Payne (2010) explored CJS responses. In the elder physical abuse cases, offenders were

more likely to receive probation, community service fines, and incarceration in jail, while offenders in elder sexual abuse cases were three times more likely than perpetrators of elder physical abuse to be sentenced to prison. Additional sentencing distinctions include: longer duration of community service for elder physical abuse cases, however probation and jail sentences were longer for perpetrators of elder sexual abuse (Payne, 2010). This finding provides additional support in the criticism of combining physical and sexual elder abuse in research and analysis.

Victims of sexual violence who reside in the community experience higher rates of initial CJS involvement and progression through the CJS compared to victims who reside in nursing homes or other residential care facilities. We know that compared to those who reside in care facilities, community-residing victims of elder sexual assault are more likely to have forensic examinations and to have evidence collected which is often instrumental to the progression of a case in CJS (Burgess, Hanrahan, & Baker, 2005). This relationship between location of residence and likelihood of CJS involvement and progression becomes more clouded when we compare responses to cases of elder sexual assault reported to APS services in the US and cases reported directly to the CJS. In the US, there are different outcomes between cases of sexual violence of older persons reported to Adult Protective Services (APS) and cases reported to the US CJS. For instance, in their exploratory study of 284 cases of elder sexual abuse, Burgess, Ramsey-Klawsnik and Gregorian (2008) found that cases reported to the CJS (either via self-reporting or third-party reporting) were more likely to occur in residential institutions and to involve rape exams compared to APS cases where victims were more likely to reside in their own homes and to not have an exam

conducted. Other differences include the higher likelihood of identifying perpetrators in APS cases compared to CJS cases. However, when identified, perpetrators in the justice system were more likely than perpetrators in the adult protection cases to be arrested, prosecuted, convicted, and to plea bargain (40% vs 5%). This is, in part, likely the result of differences in perpetrator profiles: the younger, stranger-perpetrator profile common in CJS cases, compared to the acquaintance or familial profile in APS cases (Burgess, Ramsey-Klawsnik, & Gregorian, 2008).

In a systematic review of the literature on elder sexual assault in nursing homes, Smith and colleagues (2017) identified nine studies specific to sexual assault in nursing homes, and concluded that in these studies, most cases were not prosecuted due to insufficient evidence, victim inability or unwillingness to participate, or the attorney/prosecution decision not to prosecute. This finding echoed what was reported by Pinto and colleagues (2014) and Roberto and Teaster (2005) more than a decade earlier, who found that insufficient evidence was the most commonly reported reason for lack of prosecution of sexual violence cases, a finding that was significantly more likely for women in the older age groups compared to the younger age groups.

Another factor influencing responses to suspected instances of elder sexual abuse in institutional contexts is the relationship between the victim and perpetrator. In cases where the perpetrator had a previous relationship with the victim, outsider response is less likely to occur (Burgess, Ramsey-Klawsnik, & Gregorian, 2008; Grant & Benedet, 2016). For instance, in cases of resident-to-resident sexual violence, perpetrators are often not charged at all (Burgess et al., 2005; Smith et al., 2017). Moreover, the US literature indicates that if an older victim knew the

perpetrator, the case was less likely to be referred to the CJS, less frequently investigated, and less frequently referred for prosecution, compared to cases of stranger-perpetrated sexual assault (Burgess, 2006; Burgess, Ramsey-Klawsnik, & Gregorian, 2008).

These finding are mirrored in a Canadian analysis of cases of sexual assault of older women, where not only did stranger-perpetrated sexual assault predominate the cases (60%), but instances of familial perpetrated sexual violence, including spousal perpetrated sexual violence were relatively absent (Grant & Benedet, 2016). In the only identified comprehensive study examining Canadian CJS responses to cases of sexual violence against older women (50 years and up), Grant and Benedet reviewed 3000 cases of sexual assault derived from case law searches and newspaper reports of convictions and sentences for sexual violence offences over two decades (1995 through 2015) and identified 109 cases (4 % of total) of sexual violence perpetrated against older women. Given that with only a few exceptions the community-based research indicates that older victims of sexual violence are most likely to be assaulted by someone they know compared to a stranger (Bows, 2017), and this analysis was conducted using records of sexual violence that had progressed through the CJS (i.e. reports of convictions and sentences), it is quite disturbing that "familial sexual assault, particularly spousal sexual assault, is virtually invisible in our case sample" (Grant & Benedet, 2016). What is even more alarmingly about the lack of cases is that authors reviewed sexual assaults against women over the period of the past two decades (1995-2015) in every province and territory in Canada and still found only five reported cases where family members sexually assaulted older women, and only one of which was a reported case of

spousal sexual violence (Grant & Benedet, 2016). This highlights how different cases of sexual assault disproportionality come to the attention of authorities.

Further emphasizing the suspect nature of the lack of cases in Canadian case law is the existing research that suggests that familial (including spousal) sexual assault is the most prevalent form of sexual violence against older women in the community (Bows, 2017; Grant & Benedet, 2016)**.** For instance, findings from a population-based study conducted in the European Union (n=2880) found that more than half (55%) of cases of sexual abuse of older adults were perpetrated by spouses (Luoma et al., 2011, p. 36). There is clearly a disconnect between experiences of older adults, particularly women, and what is being captured by Canadian official statistics. A disconnect that is further exasperated and partially accounted for by the finding that victims of spousal sexual violence and victims of incestuous abuse were the most likely to refuse to participate in proceedings against their perpetrators (Burgess, Ramsey-Klawsnik & Gregorian, 2008), a finding that is likely tied not only to dependency, and support, but also to stigma and shame (Sev'er, 2009).

Although conviction rates were not possible to determine in the Canadian study, Grant and Benedet reported the sentencing decisions: Among the 81 cases (involving 93 women) of sexual violence against community-residing older adults where prosecution information was available, a dangerous offender application was granted in 12 cases (resulting in an indeterminate time of incarceration), a long-term supervision order was imposed in four cases, one case there was no outcome, two cases involved offenders who were found not criminally responsible, and the remaining cases included sentences ranging from 18-months incarceration to life imprisonment

(Grant & Benedet, 2016). The same study identified 23 cases of sexual violence of older women involving 9 male serial perpetrators: six of these offenders received a federal sentence and one was designated as a dangerous offender. The proportion of dangerous offender applications was much higher than is typically found in sexual assault prosecutions, as was the proportion of cases where the perpetrator was charged with the most serious sexual violence charges: aggravated sexual assault (10%) and sexual assault causing bodily harm (13%) (Grant & Benedet, 2016). Taken together, these charges account for less than 5% of the total (N=3000) sexual assault charges, suggesting that, unlike the sentences handed down to perpetrators of sexual violence against younger victims, perpetrators of sexual violence against older women in Canada are being given comparatively harsh sentences – when *and if* these cases make it to the attention of authorities (Grant & Benedet, 2016). In fact, these researchers concluded that the greatest challenge was detecting the sexual violence in the first place. It is not known however, if this is a result of non-reporting or police failing to act (Grant & Benedet, 2016).

5.2 Suggestions and Recommendations for Responding to Sexual Assault of Older Adults

While there is limited knowledge on the responses to sexual assault among older adults, especially in the Canadian context, key themes have emerged in the literature. Not only do older women face some of the greatest barriers to reporting sexual assault (Grant & Benedet, 2016), but they also experience difficulties progressing the case through the CJS, especially if they have cognitive impairments such as dementia (Fileborn, 2016). Despite the lack of knowledge regarding

prevalence, outcomes, and responses to sexual violence among older adults, a developing body of literature identifying key recommendations or suggestions for addressing and responding to sexual assault of older adults has emerged (Ahmad & Lachs, 2002; Greenlee, 2012; Lachs & Pillemer, 2015; Malmedal, Iversen & Kilvik, 2014: Payne, 2010; Sev'er, 2009; Zink & Fisher, 2006).

The key themes within this literature include: the need to challenge societal values regarding older women and sexuality (Sev'er, 2009) and to recognize the primary types and causes of the different forms of elder abuse (Brandl & Raymond, 2012); the need to recognize older women's vulnerabilities regarding sexual violence (Fileborn, 2016; McDonald, 2011), including the need for education to ensure that older persons understand what constitutes sexual abuse (Fileborn, 2016; Naughton et al., 2013; Podnieks et al., 2010); the need for improved education and training for staff on the signs, symptoms, patterns, and risk factors of abuse associated with both victimization and perpetration (Crockett et al., 2015; Malmedal, Iversen & Kilvik, 2014; Zink & Fisher, 2006); the need to take immediate action and not compromise evidence or delay reporting (Kleinschmidt, 1997; Malmedal, Iversen & Kilvik, 2014); the importance of not blaming the victim by linking caregiver stress to abuse (Podnieks et al., 2010); and the need to move beyond the 'awareness phase' to develop, implement and test social and legal interventions for sexual violence of older persons (McDonald, 2011).

As previously discussed, older women are typically neglected as sexual beings in our society (Sev'er, 2009; Teitelman, 2006), which impacts our ability to recognize this unique population as potential victims of sexual violence, and further reduces the likelihood of health

professionals responding to suspected cases of sexual violence with forensic sexual testing and STI testing for instance (Kirkman, Kenny, & Fox, 2013). Changing views on sexuality and the sexual health of older persons is needed. In the medical and care community, shifting focus away from pathological or dysfunctional conceptions of sexuality among older persons towards a focus on satisfaction, function, and positive sexual health represents shifts that could help address needs among older victims of sexual violence, including addressing the stigma and shame that is often generationally tied to women's views of sexuality, sexual health, and sexual violence as private, family matters (Kirkman, Kenny, & Fox, 2013; Sev'er, 2009; Solomon et al., 2011; Teitelman, 2006).

In a comparative overview of sexual health policies in Australia, Canada, the USA, and the UK, researchers uncovered older women were not a priority population in terms of sexual health, as none of these countries had specific sexual health policies for midlife or older adults (Kirkman, Kenny, & Fox, 2013). While Australia and the UK have national sexual health policies (not specific to older persons), none were located for the US, and for Canada, the only national health policy was specific to guidelines for STI's and these guidelines do not specifically refer to older adults (Kirkman, Kenny, & Fox, 2013). As a result, there is clearly a gap in our knowledge and understanding of older person's unique sexual health needs, and subsequently, a gap in our understanding of unique impacts of sexual violence towards older persons. This gap is not only evidenced among health care workers, but also among older persons who lack comprehensive understanding of elder sexual abuse, and their associated risk (Naughton et al., 2013; Hussein,

Manthrope & Penhale, 2007). As such, a federal sexual health policy that supports and promotes not only positive sexual relationships among older persons, but one that is attentive to the specific health needs of older and midlife adults is needed (Kirkman, Kenny, & Fox, 2013; Solomon et al., 2011). To challenge social views that older women are shielded from sexual violence due to their 'asexual' status (Grant & Benedet, 2016; Poulos & Sheridan, 2008; Cannell et al. 2014), it is imperative that we do not assume older persons are not sexual beings, and that elder sexual abuse is understood as a distinct form of elder abuse (Bows, 2017), and a social health problem that should be talked about and that requires targeted prevention, education, and social action (Brandl & Raymond, 2012).

While there are interventions for elder abuse, less are available for elder sexual abuse, and the evidence is insufficient for any one intervention for victims or perpetrators (Ploeg et al., 2009). For instance, after analyzing the literature for key intervention models designed to address different forms of elder mistreatment, Harbison (1999) identified six distinct models with distinct explanations and factors posited as contributors to elder abuse and neglect, resulting in distinct (proposed) interventions (e.g. the psychopathological model, the systems model, the hierarchical model, the quasi-legal model, the child welfare model, and the participatory model). While quite varied in their orientation and explanations of elder abuse, all six of these models had ageist elements, and were designed by professionals, policy makers, service providers and researchers. As a result, the associated interventions and services tend to lack involvement with older persons in their development, resulting in a disconnect or gap between needs and services. The conclusions

from Haribison's (1999) analysis emphasized the importance of elder abuse explanations, understandings, and interventions that are not ageist, and that include the most important voice: older persons. In fact, including older person's voices in the development of elder sexual assault prevention and intervention policies has been suggested by other researchers (Bows, 2017; Fileborn, 2016; McGlynn & Westmarland, 2018). The implication is that by including older persons in the discussion, the social and justice responses that older persons need, and desire can be established, and their unique experiences, needs, and wants will be included in governmental policy on sexual violence (Fileborn, 2016).

While a common assumption may be that CJS involvement and perpetrator prosecution and conviction are the ideal modes of justice, research that explored sexual violence victim-survivors perceptions of justice highlights how notions of justice are not straightforward (McGlynn & Westmarland, 2018). In their study of 20 victim survivors (aged 16-74 years) of sexual violence McGlynn and Westmarland (2018) found that prosecution and conviction were not the only words victims associated with justice. In fact, most participants hesitated when asked to explain justice, however through discussions what emerged was a complex interplay of ideas, perceptions and suggestions for what 'justice' is. Authors termed this fluid, ever-changing notion of justice, "kaleidoscopic justice". Predominant themes that emerged from victims included: consequences, recognition, dignity, voice, prevention, and connectedness (McGlynn & Westmarland, 2018). Recognizing victims voices and understandings of justice can help to address sexual violence "justice gap", not only via reforms to the ways the CJS approaches sexual violence, but also

through other more informal ways that victims can experience "justice". What this study adds to our discussion is the importance of including and understanding victims' perceptions, as well as the understanding and accepting that formal CJS responses are not the only responses that lead to feelings of 'justice' among victims (McGlynn & Westmarland, 2018).

Researchers have also emphasized the need for a comprehensive, multi-sectoral collaborative federal strategy designed specifically to address elder abuse and the different types of abuse experienced by community-residing adults and adults in residential care facilities (Mosqueda, Hirst, & Sabatino, 2016; Heisler, 2012; Vierthaler, 2008). Education and training represent key elements of these suggested recommendations. Professionals often lack understanding of the laws to protect older adults (Podnieks et al., 2010), as do nurses and physicians (Almogue et al., 2010; Malmedal et al., 2009), highlighting the need for more improved knowledge, training, and education. The literature consistently emphasizes limitations that health care providers have in identifying and responding to (suspected) cases of elder sexual abuse. In general, a qualitative analysis of nurses in Canada and the UK found that hospital-based nurses were much less likely than community-based nurses to receive training related to abuse, were less likely to understand the dynamics of abuse, and were less likely to intervene (Henderson, 2001). Given that we would suspect the most serious of sexual assault cases to end up in the hospital, these findings are alarming, as are the finding from another study of medical professionals that reported staff expressed concerns over their feelings of inadequacy or discomfort when having to identify and potentially intervene in cases of elder sexual abuse (Pearsall, 2005).

There is a need for health care providers to be trained specifically to identify survivors of sexual violence among older women, to recognize their unique needs in terms of disability (Scriver, Mears, and Wallace, 2013), and to be attentive to and inclusive of diverse sexualities and genders (Cook-Daniels & Munson, 2005; Kirkman, Kenny, & Fox, 2013) that older women face when accessing services for instance. Key suggestions for training include ways to recognize and identify what injuries are consistent with different types of abuse, and what is typical in instances of aging (Heisler, 2012). Nurses, medical professionals, and residential staff should be made aware of the forensic biomarkers that are characteristic of elder sexual abuse, including bruising and genital tears or lacerations (Pearsall, 2005). Type and location of injuries (e.g. genital injuries, bruising consistent with physical force), presence of an STI, and behaviours consistent with genital injuries including difficulty walking, sitting, or using the rest room are all important for identification and disclosure (Pearsall, 2005; Teitelman, 2006). Also understanding and being aware of and picking up on potential psychological changes that occur in the aftermath of sexual violence is integral to identifying and recognizing potential instances elder sexual abuse (Burgess & Morgenbesser, 2005; Teitelman, 2006).

Physicians and other care providers should also recognize the importance of enabling private time with older patients so that questions can be properly asked in ways that older victims understand and can disclose abuse experiences in the absence of care providers and family members (Ahmad & Lachs, 2002; Zink, Regan, Goldenhar & Pabst, 2004). Key recommendations in servicing the needs of older victims of sexual violence include the importance of talking

therapies and expressive therapies that utilize music and art to convey comfort and safety when inquiring about potential victimization for instance (Burgess, n.d.; Burgess & Morgenbesser, 2005). Tailoring supports and treatments to older persons including the development and encouragement of phone counselling for older victims of sexual violence who have mobility impairments (Burgess, n.d.), and the incorporation of age-appropriate support groups or peer counseling in treatment efforts in the aftermath of sexual violence among older adults (Burgess, n.d; Harbison, 1999; Wolf, 2001) have been suggested.

Furthermore, it is important not to assume that just because a victim has a cognitive impairment or diagnosis such as dementia that he or she does not understand; after all, we know that dementia and the associated declines are not necessarily linear (Burgess, n.d; Bows, 2017). Practical and helpful guidelines are needed to help assist care providers to screen for and assess whether consent is present. For instance, it should be determined that the elder knows who the person is, and their relationship to them (i.e. ensure they do not think the person is their deceased husband for instance), and to examine whether or not they can understand risks and benefits of sexual relationships, can express levels of comfort, and can avoid sexual exploitation (Fileborn, 2016; Teitelman, 2006). However, cognitive impairments do not preclude someone from wanting intimacy and pursing meaningful relationships (Solomon et al., 2001). In fact, specifically referring to older couples, researchers emphasizing the relationship-centered perspective to aging and sexual relations have argued that sexual activity between spouses may be "morally permissible even when one partner has dementia and cannot consent" (Hagerty, 2003). Consent

is further complicated when considering the interactions between two residents who have both been diagnosed with dementia, who both are engaging in sexual relations with each other on their own free will, but who are no longer aware they have a spouse, child(ren), and are unable to recognize their families. The question becomes, do these elder patients have the ability to meaningfully consent to a new sexual relationship? (The Globe and Mail, July 14, 2018). While the law in Canada is clear and persons must be able to actively consent during every phase and stage of sexual activity (Advocate daily, n.d), who then, is responsible for determining meaningful consent? Understanding and balancing older persons rights to sexual self-determination and the protection of human rights should be included in medical training, and policies.

Within the residential setting, it is imperative that prevention policies are put into place that emphasize the need for supervision of older person's rights and potential instances of abuse (Buzgova & Ivanova, 2009). Institutional policies outlining clear ways to handle, and report cases are lacking, especially when victims have cognitive deficits (Fileborn, 2016; Henderson, 2001; Kleinschmidt, 1997; Pearsall, 2005). Care providers need to be trained to understand and recognize the vulnerability of residents (Fileborn, 2016), and should be trained on appropriate ways to routinely screen for indicators of abuse within long-term care facilities (Cohen, et al., 2007; Payne, 2010). Care providers also need to take cases seriously (Fileborn, 2016), and to be trained in appropriate ways of preserving potential evidence so as not to inadvertently destroy it by allowing the victim to bathe or by cleaning up the physical environment in which the assault occurred for

instance (Burgess & Morgenbesser, 2005; Teitelman & Copolillo, 2002), and perpetrators need to be held accountable for their acts, regardless of their relationship to their victims (Sev'er, 2009; NSVRC, 2013). Other practical recommendations for health care providers include: helping elders identify resources and social support that will allow the elder to remain in her home after the abuse for instance (Burgess & Morgenbesser, 2005); and trauma-informed service delivery that encourages listening and taking into consideration victim self-determination (NSVRC, 2013). Institutional policies therefore should be designed in such a way that they respect the balance between resident privacy and the need to protect residents from potential abuses.

Collaboration and cross-referrals with law enforcement and other appropriate social service agencies that service older persons and sexual assault victims have been highlighted as imperative (Fileborn, 2016; Malmedal, Iversen & Kilvik, 2014; Shaimberg & Gans, 2000; Zink & Fisher, 2006). For instance, senior's organizations and centres, in partnership with educators, service providers, police, among others should play a role in the education, support, and access to information via paralegals, police liaison, support groups specific for seniors, and peer counseling and/or assistance (Burgess & Morgenbesser, 2005; Haribson, 1999). When collaboration between elder and rape crisis advocates occur, the lines of communication are opened between organizations that may not typically interact often, which has the potential to lead to agency cross-training for instance (Vierthaler, 2008). Fostering a multi-faceted and multi-agency collaboration is what is needed to develop an effective and targeted approach to addressing elder sexual abuse.

The lack of information and data sources in Canada to effectively analyze rates of disclosure of sexual violence among older adults is problematic. If we want to understand the realities that older women, and older adults generally, face in terms of vulnerabilities to victimization, effort needs to focus on further developing current and future sources of data in Canada (Poole & Rietschlin, 2012). Researchers have stressed the importance of making use of existing resources such as family physicians, emergency room physicians, and nurses as providing a resource that can be useful in identifying and assessing incidence and characteristics of the problems of elder (sexual) abuse, as they are often the first formal and/or a regular recurrent contact that an older victim has after being abused (Ahmad & Lachs, 2002; Burgess & Clements, 2006; Henderson, 2001; Kleinschmidt, 1997).

As Crockett and colleagues (2015, p. 296) have urged, addressing violence against older women "requires we recognize how aging shapes when, and whether, older women report or seek help for abuse". Not only do we need to ensure that victim services are responsive to older survivors of sexual violence, but it is also imperative that we recognize that just as age influences help-seeking, so too do other elements of identity such as culture, ethnicity, sexual orientation or disability status (Crockett et al., 2015; Poole & Rietschlin, 2012). While we know there is substantial non-disclosure, many older victims of sexual violence eventually do disclose their abuse, most often to informal sources including 'another person' such as a relative or friend (Zink et al., 2006). This finding emphasizes the importance of ensuring that informal sources of support are knowledgeable about effective and appropriate ways to respond to and provide the suitable

support for older victims of sexual violence as well as information on government and community resources that can provide assistance and support. To accomplish this more work is needed to improve public information campaigns which could include ways to help both victims as well as those around them to recognize inappropriate behaviours and to react and respond appropriately (Naughton et al., 2013). Additionally, training and education for CJS officials is also warranted. The large majority of police and CJS officials have training specifically relevant to younger victims of sexual violence, if any training at all (Payne, 2010). As a result, these educational efforts and training should not only be directed towards elders, and care providers specifically, but they should also include CJS officials as well. These efforts could help to contribute to a clearer picture about sexual violence of older persons and the associated prevalence, risk and protective factors, as well as impacts, consequences, and responses to sexual violence among older persons.

6.0 CONCLUDING REMARKS: DIRECTIONS FOR FUTURE RESEARCH

In summary, what we know about sexual violence victimization among older adults in Canada is quite limited. The literature is sparse, often fails to focus specifically on instances of sexual violence and is fraught with methodological shortcomings including small sample sizes, or studies conducted with convenience samples, further impacting our ability to generalize or draw concrete conclusions. Nevertheless, this review of the literature both in North America and internationally, provides a backdrop from which to assess elder sexual assault, and highlights key elements in the study of elder sexual abuse including: issues related to terminology and definitions

of elder sexual abuse; the risk factors for victimization and perpetration; key differences in victim-perpetrator relationships; outcomes of elder sexual violence; and lastly, suggestions and recommendations for preventing, addressing, and responding to instances of elder sexual violence.

Directions for future research include a national strategy that assesses the incidence, prevalence, and characteristics of the experiences of sexual violence among older women in the community and in long-term care facilities in Canada. Sexual assault of older persons is not only the least likely form of elder abuse to be disclosed, but it is also the least likely form of sexual violence to be disclosed. The private nature of sexual victimization among older persons, coupled with ageist assumptions regarding the sexuality and sexual health of older persons complications the identification and recognition of elder sexual abuse substantially. As was stressed in earlier sections of this report, one of the first steps in addressing sexual violence of older persons, is to recognize is occurrence, and to shift typical conceptions and understandings of older persons, and more specifically older women, to be viewed as autonomous sexual beings. Other important future research should examine the longitudinal impacts of elder sexual abuse (Bows, 2017), the need for research on perpetrators characteristics (Bows, 2017; Burgess & Morgenbesser, 2005), including the examinations and evaluations of treatment or programs for perps (Bows, 2017); and the need to include older persons voices in the development of intervention and/or policy initiatives (Bows, 2017).

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