Published in final edited form as:

J Elder Abuse Negl. 2015 ; 27(4-5): 392–409. doi:10.1080/08946566.2015.1082453.

Investigations of the Sexual Victimization of Older Women Living in Nursing Homes^{1,2}

Pamela B. Teaster, Ph.D³, Holly Ramsey-Klawnsnik, Ph.D⁴, Erin L. Abner, Ph.D⁵, and Sujee Kim, M.S.⁶

³Center for Gerontology, Virginia Tech, Blacksburg, VA 24061

⁴Sociologist & Licensed Mental Health Clinician, Private Practice, 24 High Street; Canton, MA 02021

⁵Department of Epidemiology and Sanders-Brown Center on Aging, University of Kentucky, Lexington, KY 40536

⁶Graduate Center for Gerontology, Virginia Tech, Blacksburg, VA 24061

The following article presents findings from a larger study that involved collecting and analyzing information regarding alleged and confirmed cases of the sexual victimization of adults aged 18 and over who were living in long-term care facilities. Data were collected over a six-month period from five states (i.e., New Hampshire, Oregon, Tennessee, Texas, and Wisconsin) concerning reported, investigated, and substantiated sexual victimization in a variety of care settings, including nursing homes, rehabilitation facilities, assisted living facilities, psychiatric hospitals, state schools for people with developmental disabilities, and community-based residential care facilities. This article provides findings about the sexual victimization of women aged 65 and older living in nursing homes.

Literature Review

Reports of the abuse of adults over the age of 60 rose by 30% from 1996–2006. From these data are the types of substantiated abuse, including polyvictimization, to which victims were subjected: 11% involving physical abuse, 15% emotional/psychological/verbal abuse, 15% that involved financial exploitation, 37% self-neglect, 2 and 1% involving sexual abuse (Teaster, Otto, Dugar, Mendiondo, Abner, & Cecil, 2006). This study, which revealed that 66% of substantiated victims were women, relied solely on data provided by all Adult Protective Services (APS) systems nationwide. The vast majority (89%) of substantiated abuses occurred in domestic settings. In many states, APS does not have the responsibility or authority to investigate alleged abuse in facilities, hence substantiated abuses that occurred in nursing facilities in many states were not reflected in the findings.

¹The authors gratefully acknowledge funding from the National Institute on Aging, RO1 AG 022944.

²The authors also gratefully acknowledge assistance from the state APS and regulatory agency liaisons, Marta Mendiondo, Mary Tooms, Andrew Horne, Jennifer Marcum, Tenzin Wangmo, and Tim Crawford during different phases of the research process.

Corresponding author: Pamela B. Teaster, Ph.D., Professor, Associate Director, Graduate Center for Gerontology (0555), ISCE Room 105, 230 Grove Lane, Virginia Tech, Blacksburg, VA 24061, pteaster@vt.edu, Ph: 540.231.7657, Fax: 540.23.

Abuse in Nursing Homes

On any given day in 2012, 1.4 million Americans lived in nursing homes (National Center for Health Statistics, 2013). According to 2010 National Ombudsman Reporting System (NORS) data, 7% of approximately 11,000 complaints involved abuse, neglect, or exploitation: 7% involved sexual abuse, and 22% involved resident-to-resident abuse. When reporting anonymously, family members and nursing home staff have revealed both witnessing and committing elder abuse (Castle, 2012; Pillemer & Moore, 1989; Schiamberg et al., 2012). A 2002 GAO report revealed “an unacceptable level of physical and sexual abuse in nursing homes” and discusses 158 investigations of physical and sexual abuse in long-term care.

Clinical concerns in preventing and responding to the sexual abuse of nursing home residents are presented in Ramsey-Klawnsnik, Teaster, Mendiondo, Abner, Cecil, and Tooms (2007). Important among these are management responsibilities to carefully screen potential employees and to train and supervise them in ways that minimize opportunities for resident victimization. Ongoing training, supervision, and nursing care must be geared towards preventing any abuse of residents and insuring that abuse perpetrated by staff, residents, or visitors will be quickly and accurately identified and stopped and appropriate intervention offered to victims. According to President Barack Obama, in his remarks at the White House Conference on Aging (2015), there has been little change in how nursing homes address residents’ safety or quality of life in nearly 25 years.

Psycho-social symptoms of trauma and distress often exhibited by residents who have been sexually assaulted in their care facilities and the need for appropriate and informed intervention by helping professionals are discussed in Ramsey-Klawnsnik (2013). These symptoms include intense fear-based behaviors and an urgent desire to self-protect from further victimization by leaving the facility or secluding oneself to avoid again encountering the perpetrator.

Sexual Victimization

Despite the fact that various forms of elder mistreatment are underreported (Lifespan of Greater Rochester; Pillemer, & Finkelhor, 1988), no type is thought to be so underreported as that of sexual abuse (Brozowski & Hall, 2010; Ramsey-Klawnsnik, Teaster, Mendiondo, Marcum, & Abner, 2008; Rosen, Lachs, & Pillemer, 2010; Teaster & Roberto, 2004). Sexual abuse is defined as “non-consenting sexual contact of any kind” (National Center on Elder Abuse [NCEA], 1995, p.1), and includes unwanted touching; sexual assault or battery, such as rape, sodomy, and coerced nudity; sexually explicit photographing; and sexual contact with any person incapable of giving consent. Ramsey-Klawnsnik (2003) distinguishes types of sexual abuse as hands-on and hands-off offenses: *hands-on type offenses* include rape, attempted rape, fondling, harmful genital practices, oral-genital contact, prostitution of victim, sadistic sexual activity, or sexualized kissing. Alternately, *hands-off offenses* include exhibitionism, sexual jokes and comments, showing victim pornography, or voyeuristic activity.

Most research conducted on the sexual victimization of older adults has reported primarily female victims (Burgess, Ramsey-Klawnsnik & Gregorian, 2008; Ramsey-Klawnsnik, 1996; 2003; Teaster & Roberto, 2004), with a paucity of studies examining the sexual victimization of older men (Teaster et al., 2007; Roberto, Teaster, & Nikzad, 2007).

In particular, Burgess et al. (2008) reported 284 cases of alleged and confirmed sexual abuse of elders that came to official attention through report to either law enforcement or Adult Protective Services. Approximately a fourth of alleged assaults occurred in facilities. Most alleged victims were female, while the vast majority (91%) of alleged perpetrators was male. Cases first reported to law enforcement were more likely than were those first reported to APS to result in arrest and prosecution. This finding was confirmed by a later study by Payne (2010), who found differences in case dynamics and processing in 127 elder sexual abuse cases and 314 elder physical abuse cases sent to law enforcement.

Roberto and Teaster (2004) aggregated data over a five year period from substantiated APS cases concerning sexually abused older women between the ages of 70 and 89 living in nursing homes. The 50 substantiated cases revealed that the most common types of sexual abuse involved sexualized kissing and fondling and unwelcome sexual interest in the women's body. Perpetrators were usually male, with a mean age of 70 years of age and residents in the nursing home. These phenomena were also true for younger women (Roberto & Teaster, 2005), although younger women experienced more invasive types of sexual abuse than did the older women. Outcomes for the residents consisted largely of relocation and physical or psychological treatment.

In 2008, Ramsey-Klawnsnik, Teaster, Mendiondo, Marcum, and Abner examined findings from a five-state study on 119 alleged sexual perpetrators ages 21–101. Of those, 51 facility staff and 48 residents were accused. Thirty-two perpetrators were substantiated: among them were two staff members and 25 residents. There were 124 alleged victims, 77% of whom were female; substantiated were 33 victims, mean age 82. At the time of the study, none of the confirmed perpetrators was arrested.

Part of the same study, Ramsey-Klawnsnik and Teaster (2012) published findings on 46 interviews of 28 APS workers who had investigate 31 of studied cases. Findings included that the majority of facilities responded appropriately when there was an allegation of sexual abuse and that while many investigators had a lot of case experience, a quarter had little to no training on sexual abuse. Training specifically in mental health issues was recommended to aid in casework as well as a review of the standards being used to confirm a case.

Theoretical Grounding

Our work is grounded in elements of democratic governance theory (Gerring, Thacker, & Moreno, 2005) that argues that democratic governments have a central duty to protect their citizens from harm while upholding the maximum number of freedoms possible. Additionally, we employ an ethic of care (Held, 2006; Morris, 2001), which espouses that care of the highest quality should be provided to both rich and poor individuals and that achieving that goal is a shared responsibility.

Research Questions

This article reports on the analysis of investigated and substantiated reports from APS and other regulatory bodies concerning the sexual victimization of older women living in nursing homes in order to understand its nature and investigation. Specific research questions exploring differences between alleged and substantiated elder sexual victimization in nursing home included these: (a) What is the nature of the sexual abuse of older women who live in nursing homes? (b) Who are the victims and perpetrators? (c) How are cases investigated and substantiated? (d) What are the interventions and outcomes of the cases?

Methods

Data were collected concerning facility reports of the sexual abuse of vulnerable adults that were investigated and substantiated from midnight on May 1, 2005 until 11:59 p.m. October 31, 2005 from contemporaneous reports in the states of New Hampshire, Oregon, Tennessee, Texas, and Wisconsin. We developed an extensive data collection instrument, the Sex Abuse Survey (SASU) that built upon earlier work conducted by Ramsey-Klawnsnik (1996) and Teaster and Roberto (2004), as well as significant input from APS and regulatory professionals who piloted the survey. In compliance with protections for confidentiality and to ensure the highest quality of information possible, investigatory staff referred to case file information when completing the SASU. Staff members closest to the investigation were asked to complete the SASU as soon as possible after they had closed an investigation. SASUs were submitted to the research team at the University of Kentucky via e-mail, a website specifically designated for data collection purposes, and fax. In addition, SASUs were tracked by study liaisons in each state. Fifteen per cent of completed SASUs were then checked against the case file by state liaisons in order to ensure accuracy of information provided. Data gathered included personal characteristics of alleged victims, their ability to care for themselves and to communicate, a description of the sexual abuse, witness(es), time spent on and the nature of the investigations, the alleged offenders, case resolution, and outcomes for victims and perpetrators.

Statistical Analysis

Due to the limited sample size and the number of endpoints assessed, results presented in this study are strictly descriptive. For normally distributed continuous variables, we assessed differences in means using Student's *t* test. For data that did not meet the normality assumption, specifically number of hours spent on investigation, we used Wilcoxon's Rank-Sum test. To assess differences in proportions, we used the chi square (χ^2) test. Statistical significance was set at 0.05. All analyses were performed with SAS 9.3®.

Results

Our study findings reveal the myriad complexities inherent in the sexual victimization of older women living in nursing homes. Because of the small number of investigated cases (*n*=64) and to protect confidentiality, information about the women is presented in the aggregate only.

Sample

During the data collection period, participating agencies submitted reports on 438 cases of sexual abuse, nine of which were outside the study period and subsequently excluded from analysis. Five of the remaining cases did not specify a victim, and 14 did not specify an age for the victim. Consequently, our data were based on 410 cases and included 248 women of all ages (61%), mean age 55 years. Of that number, there were 64 investigations of women aged at least 65 years who were living in a nursing home.

Characteristics of the Women Victims

Victims ranged from 66 years of age to 101, mean age 81 years (Table 1). Investigations revealed that 58 of the older women were white (89%), followed by 6 (9%) African-Americans. The sexual abuse substantiation rate was 31.3% or roughly two-thirds the average APS substantiation rate for all types of abuse of adults 60+, which was 46% (Teaster, Otto, Dugar, Mendiondo, Abner, & Cecil, 2006).

Health, ambulation and ability to communicate—The majority of the women about whom allegations were investigated (70%) had Alzheimer's disease (AD) or another dementia, and 52% presented with heart disease (CHD). About a third (27%) had a physical disability (e.g., osteoporosis, cerebral palsy, Parkinson's disease), and almost a third (31%) suffered from a psychiatric disorder (e.g., psychosis, depression). Slightly over half (55%) of the women required assistance with all activities of daily living (ADLs). Over a third (39%) needed physical or mechanical help with ambulation; over a fourth (26%) were not ambulatory. Nearly half (41%) had no barriers to communication. More than half of the women (69%) were unable to manage their own finances. Nearly a third (30%) had a guardian; more than a fourth (28%) had an activated durable power of attorney for healthcare (DPOA-HC).

The abilities and needs of the 20 women whose cases were substantiated were statistically comparable (i.e., no differences by χ^2 test) to the women in the unsubstantiated cases, although we note that we had low statistical power to detect differences given our sample size. In absolute terms, women whose cases were substantiated were 8% less likely to have AD or another dementia, 24% less likely to have CHD, 16% less likely to have a physical disability, 10% less likely to have a psychiatric disorder, 8% less likely to require assistance with all ADLs, 22% more likely to be ambulatory, 16% less likely to experience barriers to communication, and were 12% less likely to have a DPOA-HC than those women for whom cases were unsubstantiated. On the other hand, when compared to the women whose cases were unsubstantiated, women whose cases were substantiated were 7% more likely to need physical or mechanical help with ambulation, 5% less likely to manage their own finances, and were no more or less likely to have a guardian.

Characteristics of the Perpetrators

The alleged perpetrator was identified in 89% of all investigations and in 90% of substantiated cases (Table 2). The average age of the perpetrators was 57.5 SD 21.6 years. Substantiated perpetrators were significantly older than unsubstantiated perpetrators (70.1 SD 19.6 vs. 51.7 SD 20.1, $t = 3.23$, $p = 0.0021$). Well over half (83%) of the alleged

offenders were male; 94% of the substantiated offenders were male, while 79% of the unsubstantiated offenders were male. Nine females were alleged as sexual abuse perpetrators, with one substantiated as an abuser. Over half (65%) of alleged perpetrators were white; 25% were African-American. All substantiated perpetrators were either white or of unknown race.

In investigations, 40% of alleged perpetrators were staff members involved in the direct care of the alleged victim, and 42% were a resident of the facility. Residents constituted 72% of confirmed perpetrators, while the perpetrator was a direct care provider in just two substantiated cases (11%). Resident perpetrators were significantly more likely to be substantiated than staff, or any other perpetrator relationship ($\chi^2 = 9.7$, 2 df, $p = 0.008$). Three-fourths (77%) of alleged perpetrators had no diagnosed disability, though 20% had a cognitive disability, and one had a history of developmental disabilities. Four perpetrators were described as abusing alcohol or other drugs, and three (two direct care providers and one resident) had criminal histories. One direct care provider had a prior allegation, but no criminal history, of inappropriate sexual behavior; the case under investigation in the current study was substantiated.

Investigations of the Sexual Victimization

In the main, the investigation was prompted by an allegation of sexual abuse (72%), although other reasons included an allegation of facility neglect by the facility itself or its staff members (23%). In 53% of cases, molestation was alleged, followed by inappropriate behavior related to sexual interest in the victim's body (20%); most allegations (81%) concerned hands-on offenses (e.g., rape, attempted rape, fondling, harmful genital practices, oral-genital contact, or sexualized kissing), but hands-on offenses were no more likely to be substantiated than were hands-off offenses (90% vs. 77%, $\chi^2=1.5$, $p = 0.2$).

In 70% of investigations and in 60% of substantiated cases, the abuse was reported to be an isolated incident, in 8% of investigations and in 25% of substantiated cases the abuse was ongoing over a period of time. In 64% of the 64 investigations, there was no witness to the abuse; cases with witnesses were no more likely to be substantiated than cases without (45% vs. 32%, $\chi^2=1.0$, $p = 0.3$). Staff witnessed the abuse in 21 situations, and nursing home residents were witnesses in two instances. For substantiated cases, there was no witness in 11 of the cases (55%), a staff witness in seven cases (35%), and a resident witness in two cases (10%). Injuries to the victim were documented in only two cases (one was substantiated). In most cases, the alleged victim was not offered and did not receive a forensic medical or nursing evaluation that would have revealed injuries inflicted by abuse.

Victim Disclosure—The victim was interviewed in over half of cases (56%) and disclosed sexual abuse 78% of the time (44% of all investigations). No cases that included a victim interview ($N=36$) were substantiated ($N=11$) without a victim disclosure, but 17 disclosures were not substantiated. The victim most frequently disclosed molestation (39%) or inappropriate behavior related to sexual interest in the victim's body (17%). Typically, one incident (61%) was disclosed. In a few instances, abuse in addition to sexual was disclosed (14%). In 28% of the disclosures, the alleged victims reported anxiety related to the incident

as well as either exhibited it behaviorally (25%) during the disclosure or exhibited no emotion whatsoever, also consistent with experiencing recent trauma (33%).

Investigatory Processes—APS or a regulatory entity investigated 55% of cases alone and 45% jointly with other entities (e.g., law enforcement, the long-term care ombudsman). Time spent in investigation ranged from 2–70 hours, with a median of six hours. For the substantiated cases, investigations ranged from 2–25 hours, with a median of six hours. There was no significant difference in investigation time between substantiated and unsubstantiated cases.

Case Outcomes

Interventions or services were offered to victims of both unsubstantiated and substantiated cases (Table 4). For alleged victims, six were offered new placements outside the facility (two refused), four were offered new placements within the facility, 17 were offered nursing care evaluations (one refused), two were offered hospitalization (one refused), 20 were offered care plan changes (one refused), eight were offered case management/counseling (one refused), 12 were offered mental health counseling (six refused), two were offered assistance with pressing criminal charges (both refused), one was offered legal intervention by APS, and eight received no offer of intervention (all eight cases were not substantiated). Two alleged employee perpetrators were fired, and three others were suspended. One-to-one staff monitoring was instituted in two cases involving resident perpetrators; male care providers were prohibited in two cases.

Of the 20 substantiated victims, four had their care plans changed, five received a nursing care evaluation, five were relocated within the facility, and one received sex abuse prevention intervention (Table 5). Seven of the women were deemed to be at continued risk of further sexual abuse, in two cases because the perpetrator was another resident who continued to live in the facility. Criminal trespassing orders were put in place in 3/7 cases. In no substantiated cases (0/20) was there an arrest of a perpetrator.

Discussion and Conclusions

The 64 investigations and 20 substantiations regarding sexually victimized older women living in nursing homes typically involved white women in their 80s. Women who were substantiated as being sexually victimized appeared to require assistance with ambulation, were unable to manage their own finances, were less likely to have a DPOA-HC and were less likely to present with dementia and physical and mental health problems than their counterparts whose cases were unsubstantiated. As a group, these alleged victims also were less likely to have communication impairments. The fact that the alleged victims whose cases were substantiated suffered less from dementia, psychiatric disabilities, and communication problems likely contributed to their being better able than the alleged victims with unsubstantiated cases to effectively and convincingly describe their victimization to investigators and hence have cases confirmed. In the present study, characteristics of the women in both unsubstantiated and substantiated cases were similar to those in earlier studies (Burgess et al., 2008; Ramsey-Klawnsnik, 2003; Roberto & Teaster, 2004), as they represent an extremely vulnerable and fragile population. Abilities and needs

of the cases of the women who were substantiated were statistically comparable to those who were not, despite the interesting and likely clinically significant differences pointed out here.

Molestation was the form of sexual abuse most frequently confirmed; three cases of vaginal rape/attempted vaginal rape were also confirmed. Hands-on offenses were no more likely to be substantiated than were hands-off offenses. Nearly half of the residents could communicate in some way. Disclosure seems to be a key to substantiation: no cases that included a victim interview were substantiated without a victim disclosure. However, it seems remarkable that 17 disclosures went unsubstantiated, particularly when victim anxiety was exhibited. We raise a concern, as we have in other publications on our findings (Ramsey-Klawnsnik & Teaster, 2012; Ramsey-Klawnsnik, Teaster, Mendiondo, Marcum, & Abner, 2008), that the level of evidence used to confirm a case may be a higher standard than actually required by law (i.e., beyond a reasonable doubt rather than preponderance of the evidence).

Similar to other studies, we were able to gather less information about alleged and substantiated perpetrators, who were identified in nearly all cases. Although it is not surprising that a statistically significant difference exists between the average age of unsubstantiated and substantiated perpetrators, a real and persistent concern emerges with the statistically significant difference in the substantiation of resident versus staff perpetrators, particularly when the number of allegations against staff members and residents were equal. Further, we express concern that investigators may be less hesitant to confirm another resident as a sexual offender than they are to confirm a staff member as a perpetrator. Although based on a small sample, one case in our data revealed that a direct care provider with a prior allegation of inappropriate sexual behavior had access to fragile residents. That this case was substantiated in the present instance raises our suspicion that another instance of sexual abuse was not confirmed due to inadequate evidence. We stress that employment of staff members with prior criminal histories warrants great scrutiny, especially when they are working among such a vulnerable population of residents.

In 60% of substantiated cases, the abuse was regarded as an isolated incident, and in 25% of substantiated cases the abuse was determined as ongoing over a period of time. For alleged sexual abuse, staff witnessed the abuse in 21 situations, and a nursing home resident was a witness in two cases; however, only seven cases in which staff members were witnesses were substantiated. Moreover, no statistically significant differences existed between cases with witnesses and cases without them. These findings are curious given the intuitive sense that witnesses should play a significant role in confirming the occurrence of sexual abuse. The authors emphasize the importance of protecting facility residents from the full spectrum of sexual offenses, including those that are both hands-on and hands-off. Sexual offenses of all types are typically injurious to vulnerable residents who are living in nursing home settings, dependent on others for their care, and for whom the locus of control is extremely circumscribed. Staff members and residents can and should play an integral role in both detection and intervention of sexual abuse.

APS or a regulatory entity investigated alone in over half of the alleged cases. Because of the complex nature of sexual victimization, which typically involves criminal activity and the infliction of physical and emotional harm on the victim requiring nuanced intervention, we recommend that APS and regulatory entities work in concert with medical, mental health, and legal professionals. Medical and mental health professionals can assist investigative staff by assessing victim harm and diagnosing and documenting abuse consequences suffered by the victim. When older adult residents with dementia are perpetrators in confirmed sexual assault cases, appropriate and creative interventions by facility staff working in concert with medical, law enforcement, APS, and licensing/health department representatives are warranted to insure the safety of all residents and staff members going forward. When a sexual crime is suspected, investigatory collaboration with law enforcement is essential and likely to increase successful prosecutions. It is striking and of concern that in none of the substantiated cases was there an arrest of the perpetrator.

The primary interventions offered to the older women were relocation outside and within the nursing homes, care plan changes, and mental health counseling (for which half refused). Of clinical note, 80% of the victims who were offered relocation following alleged assault accepted this intervention. This finding supports previous observations (Burgess et al., 2008; Ramsey-Klawnsnik, 2013; Ramsey-Klawnsnik et al., 2008) that people who have been assaulted within care facilities often feel profoundly unsafe there and should be offered relocation. Unfortunately, our findings indicate that only 16% of the 64 alleged victims were offered this assistance. The importance of using research findings to inform clinical practice is addressed in Ernst, Ramsey-Klawnsnik, Schillerstrom, Dayton, Mixson, and Counihan (2014). This finding, taken together with previous findings, is an apt example of how research regarding victimization of older adults in care facilities can inform effective clinical practice.

We find it interesting that the two residents for whom assistance with pressing criminal charges was offered both refused help. Other interventions may have been necessary and provided after our data collection period ended. We truly hope that this is the case, particularly because seven of the substantiated victims were deemed at risk of further victimization. We firmly uphold the right of abuse victims who have the capacity to make informed decisions to continue to live at risk, including making their wishes known through a DPOA-HC, but we stress that such a preference should not become an easy excuse to back away from any attempt at intervention (Ramsey-Klawnsnik et al., 2007).

We acknowledge limitations of our data collection methods. First, data on sexual abuse cases were provided by APS or regulatory staff who could have made errors in completing data collection tools despite care taken to train data collecting staff in each participating state and to check data for accuracy. Second, based on estimates from the *New York State Elder Abuse Prevalence Study*, the elder abuse case incidence rate in New York State was nearly 24 times greater than the number of cases referred to social service, law enforcement or legal authorities charged with aiding older adult victims (Lifespan of Greater Rochester, 2011). Because of the taboo nature of sexual abuse and the potential severity of its consequences, we proffer that unreported incidences of sexual abuse are even higher. Consequently, the sexual abuse of these fragile older adults is likely greater in scope than that our data

revealed. Third, although we requested information from APS and participating regulatory entities on all investigated cases of sexual abuse within our specified timeframe, information was submitted at the discretion of staff members and may not represent every case of the sexual abuse of older women in nursing homes reported and investigated.

APS and other regulatory agencies with the authority to investigate alleged sexual abuse in nursing homes require evidence sufficient to warrant confirmation of an allegation. The agencies involved in the cases in the present study were able to substantiate one out of 3 alleged cases of the sexual abuse of older women in nursing homes. The 44 alleged but unsubstantiated cases may include actual cases of sexual abuse for which investigators believed there was insufficient evidence to justify a positive finding. Many reasons exist as to why this may be the case: evidence may have become lost or contaminated, witnesses and victims may have been fearful of retaliation and recanted statements, and delays of physical examinations of alleged victims or no examinations may have occurred. Additionally and importantly, some investigators may have inaccurately applied the “beyond a reasonable doubt” rather than the legally required “preponderance of evidence” standard in making substantiation decisions (see discussion of this issue in Ramsey-Klawnsnik, 2015; Ramsey-Klawnsnik & Teaster, 2012 and Ramsey-Klawnsnik et al., 2008). The fact that some alleged cases went unsubstantiated despite victim disclosures of sexual abuse and staff members who witnessed the abuse supports this possibility. Of course, sexual abuse perpetrators are highly motivated to falsify and conceal evidence of their crimes. Thus, it is important to point out that this study does not report the actual number of incidences of sexual abuse in nursing homes during the study time period. Rather, it is an examination of only those cases that were actually reported to state authorities and investigated and those that were substantiated. It does not include unreported cases.

Despite limitations, our study represents important work on the sexual abuse of older women living in nursing home settings. Future studies should investigate sexual abuse of vulnerable adults in both facility and community settings, inquiry that has yet to be accomplished. It is imperative that researchers find creative ways to collaborate with APS, regulatory bodies, the medical and mental health and legal professions to cross-link data sets, facilitating more elegant statistical comparisons of outcomes of intervention for both victims and perpetrators. Research should address whether allegations, investigations, and substantiations of the sexual abuse of men are substantively different from those of women, from those of younger versus older victims, and of those in various care settings. Employing both theory and practice, we can determine the most appropriate responses of facilities and agencies when addressing the sexual abuse of resident versus staff abuse and the most appropriate investigators of such cases. We stress that it is critical to determine the long-term consequences for victims and perpetrators and effective prevention and intervention measures

We maintain that our findings reflect larger societal issues that affect both vulnerable men and women, much of it stemming from ageism (Butler, 2009). For example, many staff positions in nursing homes offer low salaries, demanding schedules, and high staff to resident ratios. Consequently, few people seek this type of employment, and fewer still continue in this type of employment such that turnover is a chronic problem for most

facilities. One demonstrable result is poor continuity of care, particularly egregious when it is so necessary for the life and health of older care recipients. Poor care then becomes costly care, extrinsically and intrinsically.

In summary, our findings show, first and foremost, that the sexual abuse of older women in nursing homes continues to occur. Victims are typically vulnerable due to mental or physical impairments or both. Cases appear to be substantiated at two-thirds the frequency of the average national APS substantiation rate of all forms of abuse combined including self-neglect. Alleged abusers are usually male. The confirmation of alleged sexual abuse by residents far exceeds that of facility staff, and a variety of factors seem to be correlated. Our findings confirm that offenses of sexual abuse demand sensitivity to victims and perpetrators, appropriate resources, specialized training and intervention efforts by APS, regulatory agencies, law enforcement, and medical and mental health communities. These efforts include all working in concert and community to provide safe, high quality care for its most vulnerable members.

References

- Administration for Community Living. National ombudsman reporting system data tables. 2010. Retrieved May 23, 2015 from www.aoa.gov/AoARoot/AoA_Programs/Elder_Rights/Ombudsman/National_State_Data/2010/Index.asp
- Brozowski K, Hall DR. Aging and risk: physical and sexual abuse of elders in Canada. *Journal of interpersonal violence*. 2010; 25(7):1183–1199. [PubMed: 19717787]
- Burgess A, Ramsey-Klawnsnik H, Gregorian SB. Comparing routes of reporting in elder sexual abuse cases. *Journal of Elder Abuse & Neglect*. 2008; 20(4):336–352. DOI: 10.1080/0894650802359250 [PubMed: 19042661]
- Butler, RN. The longevity revolution: The benefits and challenges of living a long life. Public Affairs; 2009.
- Castle NG. Resident-to-resident abuse in nursing homes as reported by nurse aides. *Journal of Elder Abuse & Neglect*. 2012; 24(4):340–356. [PubMed: 23016729]
- Ernst J, Ramsey-Klawnsnik H, Schillerstrom J, Dayton C, Mixson P, Counihan M. Informing evidence based practice: A review of research analyzing Adult Protective Service data. *Journal of Elder Abuse & Neglect*. 2014; 26(5):458–494. DOI: 10.1080/08946566.2013.832605 [PubMed: 24965804]
- Gerring J, Thacker SC, Moreno C. Centripetal democratic governance: A theory and global inquiry. *American Political Science Review*. 2005; 99(04):567–581.
- Held, V. The ethics of care: Personal, political, and global. Oxford University Press; 2006.
- Lifespan of Greater Rochester Inc, Weill Cornell Medical Center of Cornell University & New York City Department for the Aging. Under the radar: New York State Elder Abuse Prevalence Study - Self-reported prevalence and documented case surveys. 2011. p. 1-134. Retrieved May 11, 2015 from <http://www.lifespan-roch.org/documents/UndertheRadar051211.pdf>
- Morris J. Impairment and disability: constructing an ethics of care that promotes human rights. *Hypatia*. 2001; 16(4):1–16.
- National Center for Health Statistics. Long-Term Care Services in the United States: 2013 Overview. National Health Care Statistics Reports. 2013; 1 Table 4 Retrieved May 25, 2015 from http://www.cdc.gov/nchs/data/nshtcp/long_term_care_services_2013.pdf.
- National Center on Elder Abuse. Elder abuse in a domestic settings. Elder Abuse Information Series #3. 1995. Retrieved March 14, 2003, from <http://www.elderabusecenter.org/basic/fact3.pdf>
- Payne BK. Understanding elder sexual abuse and the criminal justice system's response: Comparisons to elder physical abuse. *Justice Quarterly*. 2010; 27(2):206–224.

- Pillemer KA, Finkelhor D. The prevalence of elder abuse: A random sample survey. *The Gerontologist*. 1988; 28:51–57. [PubMed: 3342992]
- Pillemer K, Moore DW. Abuse of patients in nursing homes: Findings from a survey of staff. *The Gerontologist*. 1989; 29(3):314–320. [PubMed: 2788108]
- Ramsey-Klawnsnik, H. Assessing physical and sexual abuse in health care settings. In: Baumhover, L.; Beal, SC., editors. *Abuse, neglect, and exploitation of older persons: Strategies for assessment and intervention*. Baltimore, MD: Health Professions Press; 1996. p. 67-87.
- Ramsey-Klawnsnik H. Elder sexual abuse within the family. *Journal of Elder Abuse and Neglect*. 2003; 15(1):43–58.
- Ramsey-Klawnsnik H. Providing Services to People Assaulted In Care Facilities. *Reshape – The Newsletter of the Sexual Assault Coalition Resource Sharing Project*, Summer Issue. 2013
- Ramsey-Klawnsnik, H. Technical Assistance Brief: Investigation Protocols. National Adult Protective Services Resource Center; 2015.
- Ramsey-Klawnsnik H, Teaster PB. Recommendations and practice guidelines from a recent comprehensive study on sexual abuse in institutions. *Generations*. 2012; 36(3):53–59.
- Ramsey-Klawnsnik H, Teaster PB, Mendiondo MS, Abner EL, Cecil KA, Tooms MR. Sexual abuse of vulnerable adults in care facilities: Clinical findings and a research initiative. *Journal of the American Psychiatric Nurses Association*. 2007; 12(6):332– 339.
- Ramsey-Klawnsnik H, Teaster PB, Mendiondo MS, Marcum JL, Abner EL. Sexual predators who target elders: Findings from the first national study of sexual abuse in care facilities. *Journal of Elder Abuse & Neglect*. 2008; 20(4):353–376. [PubMed: 19042662]
- Roberto KA, Teaster PB, Nikzad KA. Sexual abuse of vulnerable young and old men. *Journal of interpersonal violence*. 2007; 22(8):1009–1023. [PubMed: 17709807]
- Roberto KA, Teaster PB. Sexual abuse of vulnerable young and old women: A comparative analysis of circumstances and outcomes. *Violence Against Women*. 2005; 11:473–504. [PubMed: 16043559]
- Rosen T, Lachs MS, Pillemer K. Sexual aggression between residents in nursing homes: Literature synthesis of an underrecognized problem. *Journal of the American Geriatrics Society*. 2010; 58(10):1970–1979. [PubMed: 20840462]
- Schiamberg LB, Oehmke J, Zhang Z, Barboza GE, Griffiore RJ, Von Heydrich L, ... Mastin T. Physical abuse of older adults in nursing homes: a random sample survey of adults with an elderly family member in a nursing home. *Journal of elder abuse & neglect*. 2012; 24(1):65–83. [PubMed: 22206513]
- Teaster PB, Ramsey-Klawnsnik H, Mendiondo MS, Abner EL, Cecil KA, Tooms MR. From behind the shadows: A profile of the sexual abuse of older men residing in nursing homes. *Journal of Elder Abuse and Neglect*. 2007; 19(1/2):29–46. [PubMed: 18077268]
- Teaster, PB.; Otto, JM.; Dugar, TD.; Mendiondo, MS.; Abner, EL.; Cecil, KA. Report to the National Center on Elder Abuse, Administration on Aging. Washington, D.C: 2006. The 2004 survey of state Adult Protective Services: Abuse of adults 60 years of age and older.
- Teaster PB, Roberto KA. The sexual abuse of older adults: APS cases and outcomes. *The Gerontologist*. 2004; 44(6):788–796. [PubMed: 15611215]
- Teaster PB, Roberto KA. Sexual abuse of older women living in nursing homes. *Journal of Gerontological Social Work*. 2004; 4:105–137.
- White House Conference on Aging. Fact sheet. 2015. Retrieved July 28, 2015 from <https://www.whitehouse.gov/the-press-office/2015/07/13/fact-sheet-white-house-conference-aging#block-menu-block-sixteenhundrednav-main>

Table 1
 Characteristics of Older Women in Nursing Facilities Investigated as Victims of Sexual Abuse

Characteristics	Investigated Victims N=64	%	Substantiated Victims N=20	%	Unsubstantiated Victims N=44	%
Age						
65–74	17	(27)	5	(25)	12	(27)
75–84	20	(31)	5	(25)	15	(34)
85+	27	(42)	10	(50)	17	(39)
Mean age Range	81.4 (66–101)		81.6 (67–95)		81.3 (66–101)	
Race						
White	57	(73)	17	(85)	40	(91)
African American	6	(15)	3	(15)	3	(7)
Other	1	(4)	0	(0)	1	(2)
Alzheimer's disease/dementia	45	(70)	13	(65)	32	(73)
Heart disease	33	(52)	7	(35)	26	(59)
Physical Disabilities	20	(31)	4	(20)	16	(25)
Psychiatric Disorders	17	(27)	4	(20)	13	(30)
Help with all ADLs	29	(45)	8	(40)	21	(48)
Not Ambulatory	16	(26)	2	(10)	14	(32)
No communication barriers	26	(41)	8	(40)	18	(41)
Communicates verbally with difficulty	25	(39)	6	(30)	19	(43)
Unable to manage finances	44	(69)	13	(65)	31	(70)
Guardian/conservator	19	(30)	6	(30)	13	(30)
DPOA-HC	18	(28)	4	(20)	14	(32)

Table 2

Characteristics of Identified Alleged Perpetrators

	All Perpetrators N=60	%	Substantiated Perpetrators N=18	%
Age				
18–39	17	(28)	3	(17)
40–59	8	(13)	0	(0)
60–79	20	(33)	7	(39)
80+	12	(20)	8	(44)
Missing	3	(5)	0	(0)
Mean age Range	57 (19–95)		70 (30–95)	
Gender				
Male	50	(83)	17	(94)
Female	9	(15)	1	(6)
Unknown	1	(2)	0	(0)
Race				
White	39	(65)	17	(94)
African American	15	(25)	0	(0)
Unknown	1	(8)	1	(6)
Other	5	(2)	0	(0)
Ethnicity				
Not Hispanic or Latino	35	(37)	6	(33)
Unknown	22	(58)	10	(56)
Hispanic or Latino	3	(5)	2	(11)
Relationship to victim				
Facility staff	24	(40)	2	(11)
Resident/client in facility	25	(42)	13	(72)
Family member	5	(8)	0	(0)
Visitor to facility	3	(5)	3	(17)
Unknown	3	(5)	0	(0)

Table 3

Types of Alleged Sexual Abuse

Abuse	All Victims N=64	%	Substantiated Victims N=20	%
<i>Hands-on offenses</i>				
Vaginal rape/attempted vaginal rape	13	(20)	3	(15)
Anal rape	1	(2)	0	(0)
Digital penetration of vagina or anus	3	(5)	0	(0)
Molestation	20	(31)	17	(85)
Sexualized kissing	5	(8)	3	(15)
Oral genital contact	2	(3)	0	(0)
Harmful genital practices	3	(5)	0	(0)
Exposure to embarrass or humiliate	1	(2)	0	(0)
<i>Hands-off offenses</i>				
Sexual jokes and comments	2	(3)	1	(5)
Exhibitionism	2	(3)	0	(0)
Inappropriate sexual behavior related to sexual interest in victim's body	13	(20)	7	(35)

(Each case may have multiple abuses)

Table 4

Interventions Offered to Alleged and Substantiated Victims of Abuse in Nursing Homes

Intervention	All Victims N=64	%	Substantiated Victims N=20	%
None	8	(13)	0	(0)
Care plan change	20	(31)	7	(35)
Nursing care evaluation	17	(27)	5	(25)
Moving victim within facility	4	(6)	2	(10)
Case management counseling	8	(13)	4	(20)
Alternative housing	6	(9)	1	(5)
Hospitalization	2	(3)	1	(5)
Supervision increase	17	(27)	9	(45)
Mental health counseling	12	(19)	6	(30)
Sex abuse prevention	1	(2)	0	(0)
Change in staffing	8	(13)	2	(10)

(Cases can have multiple interventions)