“In the End You Keep Silent”: Help-Seeking Behavior Upon Sexual Victimization in Older Adults

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Abstract
Sexual violence is considered a prominent mental health problem. Exposure to sexual victimization during lifetime has been linked to mental health problems in old age. Research in adult victims has shown that they experience many barriers for disclosure and seeking professional help upon sexual victimization. However, information on help-seeking behavior in older victims of sexual violence is non-existent. With this study we aim for a

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better understanding of help-seeking behavior upon sexual violence in older adults. We used a mixed methods approach with an explanatory sequential design. Data were collected through structured face-to-face interviews with a random sample of 227 sexual violence victims of 70 years and older living in Belgium. Quantitative data were triangulated with qualitative data from 15 in-depth interviews with older victims. We found that up to 60% of older sexual violence victims never disclosed their experiences and 94% never sought professional help. Help-seeking is a complex process comprising several phases, which are affected by strong feelings of shame and self-blame, ageist premises and taboos about sexuality. In the end, most victims choose to cope on their own. Occasional disclosure only happens decades after the sexual violence took place. Older victims do not spontaneously disclose to healthcare workers but expect professionals to initiate the conversation. In conclusion, few older victims disclose or seek professional help upon sexual victimization. Healthcare professionals working with older adults need capacity building through training, screening tools, and care procedures to initiate conversation on sexual violence, and to detect signs, prevent, mitigate and respond to sexual victimization in older adults.

Keywords
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Introduction

Sexual violence (SV) is considered an important public health problem with major societal and judicial concern (WHA, 1996; WHO, 2002, 2015). Vast research links sexual victimization to long-lasting mental health problems (Jina & Thomas, 2013; Oram et al., 2017). In recent years, it became clear that SV in older adults occurs more frequently than previously believed. A Belgian study showed that 8% of older adults were sexually victimized in the past 12-months and 44% experienced SV during their life-course (Nobels et al., 2021a). Also, in older adults, exposure to SV during lifetime was associated with mental health problems (Ege et al., 2015; Nobels et al. 2022a; Rapsey et al., 2019).

Despite the important and long-lasting mental health impact, seeking help upon sexual victimization seems difficult. According to the “Deciding where to turn model” (DeLoveh & Cattaneo, 2017), the help-seeking process of adult victims comprises three phases. First, victims determine whether there
is a problem they need help with. Second, victims consider the available resources and finally they assess the possible consequences of using these resources. Afterwards, victims decide to cope on their own, seek (in)formal help or use professional resources without disclosing, which is termed covert help-seeking. During this process adult victims experience many barriers for help-seeking at the individual, interpersonal, and sociocultural level (DeLoveh & Cattaneo, 2017; Liang et al., 2005). At the individual level, feelings of shame and self-blame are often reported. Victims may find it difficult to label their experience as SV, have a tendency to minimize the impact of the SV incident, wish to forget or ignore the incident or solve the problem themselves (Carson et al., 2020; DeLoveh & Cattaneo, 2017; Mennicke et al., 2021; Patterson et al., 2009; Pijlman et al., 2023; Walsh et al., 2010). Moreover, victims are often unaware of the existing options for care or find it difficult to find care they trust (Holland & Cortina, 2017; Mennicke et al., 2021; Patterson et al., 2009; Walsh et al., 2010). Victims may also have difficulties to access existing services due to time, location, or financial constraints (Holland & Cortina, 2017). At the interpersonal level, fear of negative reactions from their informal network or lack of social support, may prevent SV victims from disclosing or seeking professional help (DeLoveh & Cattaneo, 2017; Mennicke et al., 2021; Walsh et al., 2010). In addition, previous negative experiences with help-seeking or a close relationship with the assailant may influence the help-seeking behavior of victims (DeLoveh & Cattaneo, 2017; Mennicke et al., 2021). At the sociocultural level, there exist many norms and stereotypes such as rape myths, which define which rape is “real” and who is a “real rape victim” (Estrich, 1987). Internalizing these rape myths may lead to victims minimizing their SV experience or having trouble labeling the incident as SV, resulting in a reduced help-seeking (Mennicke et al., 2021).

In older adults, SV is mainly researched in the broader context of elder abuse and neglect (Nobels et al., 2020). Similar to adult victims of SV, older adults who experienced elder abuse and neglect experience many barriers to disclose and seek professional help. In a systematic review, fear of harming the assailant, fear of consequences, fear of not being believed or blamed, feelings of shame, embarrassment and self-blame were identified as important barriers to seek professional help upon elder abuse and neglect (Fraga Dominguez et al., 2021). Another study identified the self-perceived level of need of the elder abuse victim as the strongest facilitators for formal help-seeking (Burnes et al., 2019). However, whether these barriers and facilitators can be extrapolated to SV in old age is unknown. In older adults, help-seeking upon SV may pose extra challenges due to prevailing ageist stereotypes on sexuality and mental health in old age. Older adults are
considered asexual by society (Gewirtz-Meydan et al., 2018). Due to this desexualization of older adults, they are considered “unfuckable” and therefore “unrapable” (Przybylo, 2021). As a result, older adults do not comply with the “real rape” stereotype, which may make it even more difficult for older victims to label their experience as SV (Bodner et al., 2018). Furthermore, although research has shown that Eye Movement Desensitization and Reprocessing (EMDR) therapy in older victims of SV leads to a significant decrease in symptoms of depression and posttraumatic stress disorder (PTSD) (Gielkens et al., 2022), it has been believed that treating traumatic experiences, such as SV, in older adults is not useful (Bodner et al., 2018). This ageist idea of “therapeutic nihilism” is still present today in many healthcare workers and older adults, subsequently affecting help-seeking behavior (Bodner et al., 2018).

To this date, knowledge on the help-seeking process and barriers in older SV victims is lacking. To provide tailored care for older SV victims, a better understanding of their help-seeking behavior is essential. In this paper, we describe the results of a mixed-method study on help-seeking behavior upon SV in older adults. We provide numeric data on (in)formal SV disclosure in older adults, and the barriers they experience. We uncover the underlying mechanisms and different phases in the help-seeking process. Based on these results, we identify avenues for future research, and formulate recommendations for policies and healthcare practices.

**Methods**

This study formed part of a research project on SV in the Belgian population aged between 16 and 100 years (Keygnaert et al., 2021). SV was approached from a rights-based and public health perspective with an overarching anti-ageist approach (WHO, 2022). The right-based perspective considers sexual and reproductive health rights (SRHR), including protection against SV, as a fundamental human right (United Nations, 2016). Ageist stereotypes might hinder the SRHR of older adults (WHO, 2021). Therefore, this research applied an anti-ageist approach (Nature Aging, 2021; WHO, 2021). We applied a comprehensive life-course approach toward SV and included SV that happened during childhood, adulthood and in old age. Furthermore, we did not prioritize age as a factor for understanding of sexual victimization in older adults. As a result, we avoided the focus on stereotypical age-related analyses based on ageist assumptions of weakness, frailty, and vulnerability (Bows, 2019; Nature Aging, 2021; WHO, 2021).

We considered an older adult as a person of 70 years and older. The onset of old age depends on context, purpose, and culture, and differs between
societies (WHO, 2002, 2021). In high-income countries, such as Belgium, people were considered “old” at the age of retirement, usually around 65 years. However, since the age of retirement has risen in many European countries and healthy life expectancy has been increasing (Falkingham, 2016), we considered 70 years as the starting age of old age.

We applied a mixed methods approach using an explanatory sequential design. In this two-phase approach, quantitative data were collected and analyzed first, followed by the collection and analysis of qualitative data. This allowed us to acquire an in-depth understanding of the phenomenon studied (Creswell & Zhang, 2009; Hussein, 2009).

In the first phase, we conducted a national representative study in older adults to provide numeric data on help-seeking behavior upon SV. The second phase entailed a qualitative study with semi-structured, in-depth interviews with older SV victims to uncover the underlying mechanisms and different phases in the help-seeking process. The study was conducted according to the WHO ethical and safety recommendations for SV research (WHO, 2016) and received approval from the ethical committee of Ghent University/University Hospital (B670201837542). Informed consent was obtained from all participants. After participation, participants received a brochure with the contact details of several helplines.

**Phase 1: Quantitative Study**

**Data Collection.** Between 8th July 2019 and 12th March 2020, 513 older adults completed a questionnaire through a structured face-to-face interview. They were selected using a cluster random probability sampling with a random walk finding approach (Nobels et al., 2022b). Interviews were conducted in private at the participant’s place of residence by trained interviewers. Both older adults living in the community and living in nursing homes or assisted living facilities were included. Participants had to live in Belgium, speak Dutch, French, or English, be at least 70 years old, and have sufficient cognitive ability to complete the interview. The participation rate was 34%. The full study protocol, including questionnaire development, selection and training of interviewers, data collection procedure, and ethical and safety measures was published elsewhere (Nobels et al., 2022b).

**Definitions, Measures, and Analysis.** The questionnaire consisted of several modules including sociodemographic characteristics, sexual health and relations, and sexual victimization. SV was measured according to the WHO definition which encompasses different forms of sexual harassment without physical contact, sexual abuse with physical contact but without penetration,
and (attempted) rape (WHO, 2015). This definition was expanded to include sexual neglect, as a result of recent insights in the field of SV in older adults (Nobels et al., 2020). We used behaviorally specific questions to assess lifetime and past 12-months SV experiences. The SV items were based on existing surveys (Keygnaer et al., 2015; Koss & Gidycz, 1985; Krahé et al., 2015) and adapted to the Belgian social and legal context (Depraetere et al., 2020). Participants who experienced SV were asked questions regarding their experiences with disclosure, seeking help from professional services and potential barriers related to the SV incident they identified as having had the most impact on their lives. If they experienced a single incident, this was automatically identified as the incident of reference.

Statistical analysis was performed using SPSS Statistics 28. Descriptive statistics were used to illustrate the sociodemographic characteristics, sexual victimization, and help-seeking behavior. Categorical variables were analyzed using chi-square tests. SV variables were grouped into hands-off (eight items) and hands-on SV (nine items), the latter being further grouped into sexual abuse (four items) and attempted or completed rape (five items). We created dichotomous variables out of all items in order to assess lifetime and past 12-months sexual victimization. A detailed overview of the SV outcome measures and questions on help-seeking behavior can be found in Appendix A/B.

Phase 2: Qualitative Study

Data Collection. Participants were either recruited through the structured interviews conducted in the first phase or through the same questionnaire-based study on SV in old age psychiatry patients (Nobels et al., 2021b). Participants who indicated that they had been sexually victimized during their life were asked whether they could be contacted for an in-depth interview regarding these experiences. Interviews took place between August 2020 and April 2021. Due to the COVID-19 pandemic and associated public health measures, most interviews were conducted via telephone or computer (with webcam). One interview was conducted face-to-face. In total, 29 older adults agreed to be contacted. Five of them could not be reached at the provided phone number after three attempts, five refused to participate in an in-depth interview, one had died in the time between the survey and the qualitative study, and three had a hearing impairment making a telephone interview impossible. Because saturation was reached, the latter three participants were not invited for a face-to-face interview. In the end 15 interviews were included in the analysis (14 from the population study, one from the old age psychiatry study).
Data were collected via semi-structured in-depth interviews. A topic list containing seven themes guided the interviews: (1) framing SV, (2) exposure to SV, (3) perceived reasons for victimization, (4) consequences of SV, (5) coping and help-seeking behavior, (6) impact on family & peers/transgenerational transmission, and (7) recommendations for prevention and care upon SV. Interviews lasted between 15 and 111 minutes and were conducted in Dutch by the first author. Citations reported in this paper were translated into English.

Analysis. Interviews were audio recorded and transcribed verbatim by the third author. Data were anonymized and confidentiality was ensured by using a pseudonym. Transcripts were checked for accuracy by the first author before the start of the first coding round and analyzed by applying thematic analysis (Braun & Clarke, 2006) using NVivo 12. Our analysis ran concurrently with the analysis of in-depth interviews with SV victims between 16 and 69 years old. Based on themes central to the topic list and recurring themes that were identified after a few interviews with both older adults and victims between 16 and 69 years old, a first theoretical code tree was developed. Starting from this baseline code tree, the researchers continued with an inductive coding strategy. All interviews were coded by the first and third author independently. The code trees from the individual researchers were merged into one and discussed with the second author to judge the consistency of interpretation and align the coding strategy (Braun & Clarke, 2006). In the next phase the codes were collated into themes, which were again discussed between the first, second, and third author to resolve all discrepancies. The themes were then further refined and regrouped until the overall story of the analysis emerged and became clearly defined.

Results

Study Sample

The study sample of the quantitative study consisted of a representative sample of the Belgian population aged 70 years and older (n=513). Within this sample, 227 older adults (44.2%) were sexually victimized during their lifetime (Nobels et al., 2021b). Their mean age was 78 years (SD: 6.0 years, range 70–95 years), 72.7% was female, 6.2% identified as non-heterosexual and 90.3% was community-dwelling. Over 80% experienced sexual harassment, 57.3% sexual abuse and 14.1% (attempted) rape. Almost one in five (18.9%) reported being sexually victimized in the past 12-months. There was a significant higher proportion of last 12-months victims within the non-heterosexual respondents compared to the heterosexual respondents (p = .002).
Fifteen SV victims participated in the qualitative study. Their mean age was 77 years (SD: 3.9 years, range 71–85 years), 80.0% was female, 6.7% identified as non-heterosexual and 93.3% was community-dwelling. Over 93% experienced sexual harassment, 80% sexual abuse and 60% (attempted) rape. Almost one in six (13.3%) had experienced sexual victimization in the past 12-months. More information on the characteristics of both study samples can be found in Tables 1 and 2.

### Help-Seeking Behavior Upon Sexual Victimization in Older Adults

The majority of older victims (59.9%) never disclosed their SV experience(s) (see Table 3). If they had disclosed, it most often was shared with their partner (41.8%), a friend (30.8%) or another family member (26.4%). Less than 6% sought professional help.
The most frequent reasons not to seek professional help were linked to the victim (see Table 4). Almost half (48.6%) reported not needing professional help. Others cited embarrassment (15.0%) and fear of not being believed (10.7%). Some indicated reasons linked to others, such as wanting to protect the assailant (7.5%). A small group experienced barriers linked to accessibility and 4.7% identified other barriers. The barriers for contacting professional help did not differ significantly between victims who experienced SV in the past 12-months versus victims who did experience SV during their lifetime, but not in the past 12-months ($p > .005$).

The Process of Help-Seeking Upon Sexual Victimization in Older Adults

In the following part we present the results of the thematic analysis on disclosure and seeking professional help upon SV in older victims. We identified six themes: (1) Do I (still) deserve help? (2) Today it would be dealt with differently, (3) What will happen when my story is out there? (4) Coping on my own, (5) (Late) disclosure, and (6) Taboos about sexuality.

Theme 1: Do I (Still) Deserve Help? For older SV victims, a first step toward disclosure and seeking professional help is to identify themselves as a SV
victim. In that regard, they need to recognize their experience as SV ("Was this sexual violence?") and the way it impacted them ("It was not important"). Moreover, older victims considered if the impact they experienced could still be changed at this age ("It is too late"). Many victims lingered at this first decision point, even when the SV happened several decades ago.

"Was this sexual violence?" How older victims interpreted their own SV experience, was defined by how they identified their experience and the extent to which they blamed themselves for its occurrence. Several victims had difficulties identifying their experience as SV, especially when there was no penetration or physical aggression involved. They preferred the term sexually transgressive behavior instead of SV.

Well actually that wasn’t really sex, he never penetrated. It was just my hand on his penis but as a child that felt quite weird. —Eliana, 76 years, female

I don’t want [to call it] violence, violence absolutely not. But, sexually transgressive behavior . . . yes. —Francine, 76 years, female

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**Table 3. Help-Seeking Upon Sexual Victimization in Older Adults (n = 227).**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Disclosure&lt;sup&gt;b&lt;/sup&gt;</th>
<th>n (%)</th>
<th>Professional help</th>
<th>n (%)&lt;sup&gt;a&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
<td>136 (59.9)</td>
<td>Partner</td>
<td>38 (41.8)</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>91 (40.1)</td>
<td>Parent</td>
<td>15 (16.5)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Other family member</td>
<td>24 (26.4)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Friend</td>
<td>28 (30.8)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Acquaintance</td>
<td>21 (23.1)</td>
</tr>
<tr>
<td>Disclosure&lt;sup&gt;b&lt;/sup&gt;</td>
<td>No</td>
<td>214 (94.3)</td>
<td>General practitioner</td>
<td>6 (46.2)</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>13 (5.7)</td>
<td>Medical specialist (excl. psychiatrist)</td>
<td>/</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Mental health practitioner (incl. psychiatrist)</td>
<td>1 (7.7)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Other&lt;sup&gt;c&lt;/sup&gt;</td>
<td>6 (46.2)</td>
</tr>
</tbody>
</table>

<sup>Note.</sup> These results concern the sexual violence incident with the most impact on the victim. This concerned sexual harassment, sexual abuse and (attempted) rape in 50.3%, 40.1%, and 9.6% of the cases respectively.

<sup>a</sup>Participants could indicate multiple options, therefore the total is >100%.

<sup>b</sup>Disclosure = disclosure prior to the interview.

<sup>c</sup>This group contains participants who contacted a sexual assault care center, a helpline, a support group, or another form of formal support.
Table 4. Barriers to Contacting Professional Help Upon Sexual Victimization in Older Adults (n = 214).

<table>
<thead>
<tr>
<th>Variable</th>
<th>Lifetime SV (incl. past 12 months) n (%)&lt;sup&gt;a&lt;/sup&gt;</th>
<th>% Past, 12 months SV</th>
<th>% Lifetime SV (excl. past 12 months)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reasons linked to the victim</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I didn’t need help</td>
<td>104 (44.9)</td>
<td>44.2</td>
<td>45.1</td>
</tr>
<tr>
<td>I thought nothing could be done</td>
<td>13 (5.7)</td>
<td>5.4</td>
<td>7.0</td>
</tr>
<tr>
<td>I felt embarrassed about what happened</td>
<td>32 (14.1)</td>
<td>11.6</td>
<td>14.7</td>
</tr>
<tr>
<td>I would not be believed or taken seriously</td>
<td>23 (10.1)</td>
<td>4.7</td>
<td>11.4</td>
</tr>
<tr>
<td>I didn’t trust anyone</td>
<td>11 (4.8)</td>
<td>0.0</td>
<td>6.0</td>
</tr>
<tr>
<td>Reasons linked to others</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I was afraid of further violence</td>
<td>10 (4.4)</td>
<td>0.0</td>
<td>5.4</td>
</tr>
<tr>
<td>I didn’t want the person who did this to me to get in trouble</td>
<td>16 (7.0)</td>
<td>4.7</td>
<td>7.6</td>
</tr>
<tr>
<td>I didn’t want to bring a bad name to the family or group I belong to</td>
<td>10 (4.4)</td>
<td>0.0</td>
<td>5.4</td>
</tr>
<tr>
<td>Reasons linked to accessibility</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I didn’t know where to go</td>
<td>14 (6.2)</td>
<td>0.0</td>
<td>7.6</td>
</tr>
<tr>
<td>I wasn’t able to go due to financial or transportation limitations</td>
<td>1 (0.4)</td>
<td>0.0</td>
<td>0.5</td>
</tr>
<tr>
<td>Other reason</td>
<td>10 (4.4)</td>
<td>0.0</td>
<td>5.4</td>
</tr>
</tbody>
</table>

Note. These results concern the sexual violence incident with the most impact on the victim. This concerned sexual harassment, sexual abuse and (attempted) rape in 50.3%, 40.1%, and 9.6% of the cases respectively. SV = sexual violence.

<sup>a</sup>Participants could indicate multiple options, therefore the total is >100%.
Furthermore, even many years after the SV, victims blamed themselves for its occurrence. This self-blame withheld victims from disclosing or seeking professional help for many years. Even today it remained difficult for victims to talk about it. They seemed to think they didn’t deserve help, because it was their own fault.

I could, I could, I could not let it go. I could not get over it. Well, I could not imagine this had happened to me, me always being confident, [someone] who... always demanded her place etc... That is why I never allowed help. It’s my character, I think. No, I will fix this, no, they cannot help me or something like that. I think. But I have always been very independent and confident [. . .]. I could not believe it had such an impact on me. I always blamed myself. —Mieke, 75 years, female

“It was Not Important.” Although several victims experienced important mental, sexual and reproductive health problems throughout their life, they often did not link them to their own SV history. Severe consequences such as flashbacks during sexual intercourse or depressive complaints did not prompt victims to disclose or seek professional help. Many victims seemed to cope with the experience by considering it as not important or not serious. Hence, they convinced themselves they did not need nor deserve help.

It was not worth the effort. I don’t have the impression that, I do know that it had an impact, but not so much that I suffered because of it, I think. It was always there unconsciously, you know it’s there, but I cannot say, I don’t think I really was traumatized by it. —Eliana, 76 years, female

“It’s Too Late.” Furthermore, older victims contemplated whether disclosing or seeking professional help in this phase of life could still make a difference. Several victims indicated a kind of acquiescence with the fact the SV could not be undone anymore. It seemed they accepted they were too old to still deserve help for experiences that happened many years ago.

Who can help me anyway? You just have to accept it, what can you still do? Just get over it and get on. —Henrica, 73 years, female

Theme 2: Today it Would be Dealt with Differently. Once older victims identified their own experience as SV, they started to consider the possible (in) formal resources for help-seeking. They mainly reflected about the difference between the availability of resources nowadays and at the time they experienced SV. They recognized that the resources when they were victimized
were very limited or even non-existent. And even if there were resources available, they did not know they existed or how to access them.

> I have never sought any help or called the police [...] I had no idea this was possible. —Lidia, 78 years, female

Moreover, general societal attitudes toward disclosure or seeking professional help upon SV were negative at the time. Participants described how it was common practice that victims were not believed or even ridiculed.

> No, I had to, actually in the 1960s, if you asked for professional help, you just weren’t believed. —Francine, 76 years, female

Older victims acknowledged the major societal changes in the past years, for example, the MeToo campaign, which made disclosing SV more acceptable. They recognized professional resources being more available and accessible nowadays. Several victims believed that if they were victimized today, they would disclose to a professional.

**Theme 3: What will Happen When my Story is Out There?** Older victims worried about the possible consequences of disclosing their story to a family member, friend, or professional. They were afraid to lose control about what would happen when their story was out in the open. They mainly worried about harming others ("Will I harm others?") and about other people’s reaction ("What will people think?").

"Will I Harm Others?" Victims mainly worried about harming the assailant or relatives of the assailant, especially when the assailant was known to the victim. Several victims questioned the “bad” intentions of the assailant or feared the reaction of the assailant and possible further violence. Moreover, some victims pondered about how their story might impact relatives of the assailant. One victim, who was sexually abused by her sister’s husband, waited until most of her family members died to disclose her experiences to her only remaining sister. In this way she could minimize the impact of her narrative on her family members’ lives.

> Yes, I only told my sister about him. I only have one sister alive. There were five of us and the others are already dead, so I did tell my sister who is still alive. [...] No, no, no, [I] never [told it] to my other sister (wife of the assailant), never. —Eliana, 76 years, female
"What Will People Think?" Older victims anticipated negative reactions from the (in)formal resources they considered. These expectations were linked to the prevailing negative societal attitudes toward disclosure and professional help-seeking when they were victimized, and previous experiences with help-seeking. Many victims described a fear of not being believed, not being taken seriously or blamed for the occurrence of SV.

It was not credible, even if you spoke up. You always got the blame. In fact, the blame was always bounced back to you . . . And in the end you keep silent.
—Francine, 76 years, female

Some victims reported that they were afraid of professionals reacting disproportionately to their story, which prevented them from disclosing to professional services.

I was afraid [to talk to a professional], because I thought they were going to say “You should tell this to someone else.” I did not want to make it public. What would people think of me? How would I be labeled? [. . .] I might have just made people even more curious. I said to myself, “I want to be left alone.”
—Maurice, 71 years, male

Theme 4: Coping on my Own. The majority of older victims decided, at least for a large part of their life, to deal with their SV experiences on their own. Over their life-course they developed several coping strategies (Avoiding or minimizing the experience). Although older victims came in contact with professionals, they did not spontaneously disclose to them (Staying silent while being in contact with professionals).

Avoiding or Minimizing the Experience. Older victims described several coping strategies they had applied throughout their lives. A common strategy was avoidance. This mainly involved avoiding any thoughts about what happened, by avoiding the assailant and any reminders of the SV. One victim, who experienced SV at the workplace, explained it like this:

I did not go back. I have worked a while in a smaller branch [of the same firm], but I never went back. Mainly because I wanted to avoid him [. . .] It stopped, without anyone knowing it, without the need for interference from anyone. This was perfect for me. This was perfect in fact and nobody was discredited.
—Maria, 80 years, female

Victims tried to cope by minimizing or normalizing their experiences or the impact it had on their lives, which largely overlaps with the concepts
described in “Do I (still) deserve help.” This shows that older SV victims went back and forward between the different phases in the decision-making process in order to meet their needs for disclosure and professional help.

Several victims attempted to make sense of their experience by preventing the next generation from experiencing the same without disclosing their own experiences. They provided their children with comprehensive sexual education, which was more progressive than generally accepted at that time. If my children asked questions [about sexuality], I always answered. I did not say I don’t know and if I didn’t know we looked it up. I have always been open with my children [. . .] I believe this is very important. Maybe I find it important because of what I experienced. If I had not experienced it, I would have never thought about it. It would have never occurred to me. —Henrica, 73 years, female

*Staying Silent While Being in Contact with Professionals.* Many victims came in contact with professional services during their lives. However, none spontaneously disclosed their SV experiences to a professional because of several reasons: lack of time of the professional, lack of privacy (e.g., due to an intern or family member being present) and not wanting to burden the professional with extra problems. However, older victims seem willing to disclose SV, but expect professionals to initiate the conversation.

Actually, I think people answer that [question] directly, without thinking about it. It’s on your mind and you cannot tell it to anyone . . . But nobody asks you about it. They just don’t ask. —Georgette, 74 years, female

**Theme 5: Late Disclosure.** Few victims decided to disclose their SV experience to a family member, friend, or a professional. This happened in the majority of cases many years after the SV took place. Victims were more inclined to disclose if they anticipated trust and felt in control about what would happen with their story.

I told this for the first time to the person I now have a relationship with, [. . .] who I really trust. She is the only one who knows. —Thiery, 72 years, male

Victims received mainly negative reactions upon disclosure, such as not being believed, being blamed, or even sexual harassment. Several victims reported that their story was disregarded by the one they disclosed to. Their story was “out there,” but it was never discussed again. This made victims very uncomfortable as they felt they had lost control over their narrative. They described feeling abandoned by their confidants. As a results of these
negative reactions, victims returned to coping on their own. It was subsequently very difficult for them to disclose their experience again later in life.

Theme 6: Taboos About Sexuality. A central theme in the help-seeking behavior in older victims, was taboos about sexuality when they grew up. This had an impact on different phases in their help-seeking process.

Firstly, taboos about sexuality impacted the way older SV victims could identify themselves as such (theme: Do I (still) deserve help?). Due to a lack of comprehensive sexual education, several victims did not know anything about sexuality, and as a consequence had no idea they were sexually victimized. Moreover, older victims were unaware SV could happen between marital partners. It seemed older victims could not find the right words to describe what had happened to them. One victim explained that over the years she found more words to describe what she had experienced, which in turn altered her thinking about what had happened:

It is difficult to say what I mean exactly. It’s difficult, because you never thought about it concretely. You experienced it, but you never put it into words [. . .]. Maybe we did not think about it, because we could not talk about it. Then you stay in your own thoughts and you don’t hear other [opinions]. You look blind [. . .]. The more you can talk about it, the more thoughts you get about it.
—Hortensia, 73 years, female

Taboos about sexuality contributed to the victim’s self-blame. Sexuality was seen as something sinful. Because they had engaged in sexual activity, victims believed they became sinful themselves. They were convinced they had done something to provoke the behavior of the assailant. As a result, they decided they did not deserve help for their “wicked” behavior.

But that was also mostly because of societal norms in the past. [. . .] If something happened it was always “You must have provoked it.” That is, that was and I didn’t understand, because how do you provoke it? [. . .] You were young and you didn’t really understand. That it was your fault and then you don’t talk about it anymore. That [it is] now your fault because you just don’t understand. That was taboo before, sex was taboo anyway. It was not talked about. Not in a negative or not in a positive sense. No there was no talking about it. [. . .]. Sex didn’t exist. Sex didn’t exist. —Hortensia, 73 years, female

Second, the taboo on sexuality influenced the knowledge of older victims on the available (in)formal resources and their attitudes about disclosure and professional help-seeking (theme: Today it would be dealt with differently). Since talking about sexuality and SV was not permitted, resources were very
limited or even non-existent. Moreover, when victims came forward with sexual victimization they were blamed for its occurrence or were not believed.

You couldn’t do that before [ask help upon SV]. You could only get bullied. But no no. I like it much better now. There is help and people are listened to and people can express themselves. —Prudence, 85 years, female

Thirdly, because of taboos about sexuality, victims were concerned about the consequences of their possible disclosure or professional help-seeking (theme: What will happen when my story is out there?). They worried that disclosing their experiences would bring a bad name upon themselves and their family, as their own “sinful” behavior would reflect badly on anyone connected to them.

**Discussion**

In this paper we present the results of a mixed methods study on help-seeking behavior upon SV in older adults. In the discussion section we triangulate the results of the quantitative and qualitative study.

Our quantitative results show few older victims sought help upon SV. Around 40% had informally disclosed their experience(s), which is less compared to the 50% disclosure rate found by a Belgian study with SV victims between 16 and 69 years old, and the 65% disclosure rate reported in a recent Dutch study (Keygnaert et al., 2021; Pijlman et al., 2023). Only 6% of older victims in our sample had ever sought professional help, which is comparable to 8% of adult victims in the Belgian study (Keygnaert et al., 2021), but less compared to the 23% found in the Dutch study (Pijlman et al., 2023). The main barriers older victims experienced to contact professional help were a self-perceived idea of not needing help, embarrassment, fear of not being believed and wanting to protect the assailant. These results are similar to previous studies on formal help-seeking upon SV in adult victims and in victims of elder abuse and neglect (Burnes et al., 2019; Carson et al., 2020, DeLoveh & Cattaneo, 2017; Fraga Dominguez at al., 2021; Mennicke et al., 2021; Patterson et al., 2009; Pijlman et al., 2023; Walsh et al., 2010). Moreover, the barriers for help-seeking did not differ between older adults who were victimized in the past 12-months and older adults who were victimized during lifetime, but not in the past 12-months.

The help-seeking process of older victims shows similarities and differences to that of adult victims. Like adult victims, older victims go through three phases when seeking help upon SV (DeLoveh & Cattaneo, 2017). However, the concrete manifestation of these phases differs in the perception
of victims while aging. Therefore, we propose an adaptation to the “Deciding where to turn model” for older SV victims (DeLoveh & Cattaneo, 2017) (see Figure 1).

In the first phase, older victims determine whether there is a problem they need help with (theme: “Do I (still) deserve help”). Similar to adult victims, they have difficulties in identifying their own experience as SV and tend to minimize the impact of their SV experience (Carson et al., 2020, DeLoveh & Cattaneo, 2017; Mennicke et al., 2021; Patterson et al., 2009; Pijlman et al., 2023; Walsh et al., 2010). It seems, however, that strong feelings of shame and self-blame combined with the internalized ageist idea of therapeutic nihilism, does not only lead older victims to believe they do not need help; it convinces them they do no longer deserve help because of their age. This ageist premise adds an extra dimension to the help-seeking process of older victims compared to adult victims.

In the second phase, older victims consider the available resources. While younger victims draw intuitively on their knowledge of the available resources (DeLoveh & Cattaneo, 2017), older victims compare the resources and general attitudes toward disclosure and professional help-seeking from the time they were victimized with today (theme: “Now it would be dealt with differently”). They acknowledge major societal changes in the past years, like the MeToo movement, which made talking about SV more acceptable.

In the third phase, older victims weigh the consequences of using the available (in)formal resources (theme: What will happen when my story is out
there?). They worried about the opinion of others, and feared not being believed or being blamed for the SV, which are similar to worries of adult victims (DeLoveh & Cattaneo, 2017; Keygnaert et al., 2021; Mennicke et al., 2021; Walsh et al., 2010). Like victims of elder abuse and neglect, older SV victims worried about the possibility of harming others and breaking family ties (Burnes et al., 2019; Fraga Dominguez et al., 2021).

Unlike adult SV victims, the taboos about sexuality were a central theme in the help-seeking process of older SV victims (theme: Taboos about sexuality). These taboos influenced all three phases of the help-seeking process. They contributed to the strong feelings of shame and self-blame and made it difficult for older victims to identify themselves as such, as they lacked knowledge about positive and negative aspects of sexuality.

As a result of the cognitive and emotional process represented by the different phases, most older victims made the choice to cope on their own (theme: Coping on my own). Like adult victims, older victims mainly used an avoidant coping strategy (Carson et al., 2020, DeLoveh & Cattaneo, 2017; Mennicke et al., 2021; Patterson et al., 2009; Pijlman et al., 2023; Walsh et al., 2010). Older victims, unlike adult victims, also applied “transgenerational coping.” To come to terms with what happened, they tried to prevent the next generation from experiencing the same, by talking openly about sexuality with their children and provide them with comprehensive sexual education. Even when in contact with professionals, older victims decided to stay silent. This seems similar to the covert help-seeking described in adult victims (DeLoveh & Cattaneo, 2017). However, according to DeLoveh and Cattaneo (2017), the adult victims were aware their complaints were associated with sexual victimization when they contacted a professional. They consciously decided not to disclose their experiences. While the older victims in our study were not aware of the link between their complaints and their SV history or contacted a professional for a problem unrelated to their sexual victimization. Therefore, we decided not to make this a separate theme, and rather placed Staying silent while being in contact with professionals under Coping on my own. Only few victims sought help from (in)formal resources to come to terms with what happened, mostly decades after the SV occurred (theme: Late disclosure).

Implications for Clinical Practice

Although many older adults did not spontaneously disclose their SV experiences to professionals, they are willing to break the silence when asked about it. It is known disclosure has a narrative effect. By disclosing, hidden information gets meaning, which leads to a decreased accessibility of hyper-accessible secrets in one’s consciousness (Kelly & McKillop, 1996;
Wegner & Erber, 1992) and often results in a meaningful resolution of the secrets (Pennebaker, 2000). Disclosing SV may help older victims to reconcile themselves with what happened and the choices they made as a result (Hargrave & Anderson, 1997). Recent Dutch research also indicated that trauma therapy decreases symptoms of depression and PTSD in older SV victims (Gielkens et al., 2022). Hence, it is never too late to disclose or seek professional help upon SV. Given the high prevalence numbers of SV in older adults, both during lifetime and in the past 12-months, and the important mental health impact of sexual victimization in old age (Ege, 2015; Nobels et al., 2021b, 2022a; Rapsey, 2019), we recommend a routine inquiry about sexual victimization in all older adults with mental health problems. However, research has shown healthcare workers do not feel comfortable discussing SV with older adults (Goldblatt et al., 2020; Gott et al., 2004; Saunamäki & Engström, 2014). Therefore, there is an urgent need for capacity building around SV in older adults for all healthcare professionals who work with older adults. This should include specific training and development of detection tools and care procedures to increase the capacity of healthcare workers to initiate conversations on SV and to better detect signs, prevent, mitigate and respond to SV in older patients. In addition, an interdisciplinary expert group consisting of researchers, policymakers, and professionals should investigate how care for older SV victims, including victims of recent and non-recent SV, can be more accessible, acceptable, and affordable.

**Limitations and Strengths**

Our study has several limitations. Both study samples included only a small proportion of nursing home residents and male victims were underrepresented in the qualitative study. Our results therefore may have limited generalizability to SV in nursing homes residents or in older males. More research is needed to assess specific help-seeking needs and barriers in these populations. Nevertheless, despite these limitations, our study is the first in its kind to research disclosure and professional help-seeking upon SV in older adults and can be regarded as an important step toward a better understanding of the help-seeking process in older SV victims.

**Conclusion**

Older adults rarely disclose or contact professional services upon sexual victimization. Help-seeking behavior upon SV is a complex process, which comprises different steps. Older SV victims tend to minimize their experience(s)
and its impact. Self-directed ageist premises and taboos on sexuality add extra dimensions to the help-seeking process in older SV victims, which are not present in adult victims. Older victims do not spontaneously disclose SV and expect healthcare workers to initiate the conversation. Hence, healthcare professionals need to be educated through training, detection tools and care procedures to initiate conversations about SV, to better detect signs of SV, and to prevent, mitigate, and respond to SV in older patients. Furthermore, an interdisciplinary expert group consisting of researchers, policymakers, and professionals should investigate how care for older victims of recent and non-recent SV can be more accessible, acceptable, and affordable.

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**Authors’ Contributions**

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**Supplemental Material**

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