Research Paper

Professionals' Awareness of Sexual Abuse in Late Life: An Exploratory Survey

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Abstract

BACKGROUND: The sexual abuse phenomenon is considered taboo. It has been discussed, to date, mainly in relation to children and young women, with insufficient attention to sexual abuse in a late-life context. **OBJECTIVES:** The aim of this survey was to explore professionals' awareness of elder sexual abuse (ESA). **DESIGN:** The survey was conducted among 161 Jewish and Arab professionals from health care and social services, who worked with older adults in Israel. **RESULTS:** Of the entire sample, 70 professionals (only 43%) reported encountering at least one to three cases of ESA. A total of 98% of the victims were women, and the primary offender was the spouse (75%). In most cases (70%), the victim reported the abuse, which was mainly sexual assault (64%). All participants (100%) noted taking action. **CONCLUSION:** This exploratory survey indicates that professionals are partially aware of the existence of and the need to address the ESA phenomenon.

Keywords

awareness, elder abuse, elder mistreatment, elder sexual abuse, intimate partner violence, older adults, survey

Family violence, as a multifaceted phenomenon, has received increased research and practice intervention attention over the past four decades. To date, intimate partner violence (IPV) and elder mistreatment are acknowledged as social and health problems (Band-Winterstein, 2012; Sommers, 2006). However, sexual abuse of older adults (elder sexual abuse [ESA]) has received little attention to date. Recently, several studies have addressed the issue (Burgess, Ramsey-Klawsnik, & Gregorian, 2008; Malmedal, Iversen, & Kilvik, 2015; Osgood & Manetta, 2003; Rosay & Mulford, 2017), but the phenomenon is still not recognized as a social problem in old age. Health and welfare professionals play a central role in identifying, intervening with, and giving voice to the victims, and exploring practitioners' awareness of ESA is, therefore, essential.

Awareness of elder abuse and neglect in Israel has increased over the past two decades (Eisikovits, Winterstein, & Lowenstein, 2005), leading to professionals in health care and welfare organizations becoming engaged in elder-abuse-related initiatives. In 1989, the Israeli Knesset introduced Amendment 26 to the Penal Code, imposing mandatory reporting, by professionals, of abuse and neglect of the "helpless" (i.e., those unable to defend themselves, such as, children, older adults, and people with disability). The law states explicitly that physical, psychological, or sexual abuse of the helpless, or neglect, whether by omission or commission, is considered a criminal offense and subject to severe punishment. The obligation to report such cases to a court welfare officer or to the police applies to all members of the public and particularly to professional care workers (Alon, Schindler, Doron, & Yooz, 2013). In the case of ESA, little is currently known about professionals' awareness of the phenomenon in Israel (Alon, 2016). To address this issue, our initial step was to gather information about ESA from Israeli professionals who worked with older adults.

Sexual Abuse Along the Life Course

Sexual abuse is defined as forced sexual behavior or a consensual behavior due to threats or exploitation of authority (Jewkes, Sen, & Garcia-Moreno, 2002; World

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Health Organization, 2013). In this regard, the World Health Organization defined sexual behavior as violence, even if it "occurs when the person aggressed is unable to give consent—for instance, while . . . mentally incapable of understanding the situation" (Jewkes et al., 2002, p. 149). This definition might be especially significant vis-à-vis older adults because of the risk of cognitive and mental decline. Sexual abuse takes several forms—some include physical contact and are identified as sexual assault, expressed by rape or attempted rape, and forcible sodomy (Felson & Cundiff, 2014; Leserman, 2005; Smith & Skinner, 2012). Other forms do not include physical contact, for example, indecent assault (i.e., unacceptable sexual behavior such as forcing someone to watch pornography or masturbation), sexual temptation without consent, sexual verbal harassment, voyeurism, and exhibitionism (Monson, Langhinrichsen-Rohling, & Taft, 2009).

Sexual abuse in general, and in old age in particular, is directed primarily against women, from childhood through old age, by family members and formal caregivers at home or in institutions (Abramsky et al., 2011; Friedman et al., 2011; Teaster & Roberto, 2004a). The etiology of the abuse is attributed to four main dimensions. The first is social factors, such as the patriarchal-traditional construction (Burgess & Clements, 2006; Osgood & Manetta, 2003). The second dimension relates to psychological factors such as offenders' psychopathologies and personality disorders, including the need for superiority and control. The third dimension, physiological/biological factors, is caused by hormonal dysfunction and/or damage in the brain due to cognitive deterioration or other illnesses resulting in impulsive and/or aggressive behavior (Rosen, Lachs, & Pillemer, 2010). The fourth and final dimension focuses on interpersonal relationships, such as early abuse experiences or sexual abuse as a result of inadequate communication patterns between spouses (McClellan & Killeen, 2000; Monson et al., 2009; Ogloff et al., 2012). Studies indicate that the consequences of sexual abuse for older victims can include genital trauma (bruises, abrasions, and lacerations; Burgess et al., 2008; Eckert & Sugar, 2008), as well as psychological impact, manifested in cumulative trauma reactions expressed by biological, physical, emotional, and functional indicators (Lin, Epel, & Blackburn, 2012; Shrira, 2012).

Sexual abuse as a phenomenon is shaped by taboo, stigma, and prejudices. The social construction of the phenomenon is commonly expressed by blaming the victims for provoking and causing the abuse or for remaining in the abusive relationship (Bennice & Resick, 2003; Easteal & McOrmond-Plummer, 2006). As a result of the abuse, the victims express physical and emotional distress. These include chronic and acute somatic symptoms (Hart-Johnson & Green, 2012); health problems, such as sexual dysfunction, pelvic and urinary infections, and insomnia (Dillon, Hussain, Loxton, & Rahman, 2013); and psychological disorders, such as posttraumatic stress disorder, depression, and anxiety (Masho, Odor, & Adera, 2005). Sexual abuse also affects victims' physical and self-image, thus limiting their ability to trust others in interpersonal relationships or to have a sense of control over their lives (Herman, 2008).

Elder Sexual Abuse

Although sexual abuse has been widely studied in the context of children and young women, only few studies have addressed sexual abuse in late life, even though the phenomenon has already received formal acknowledgement (Iversen, Kilvik, & Malmedal, 2015; Lea, Hunt, & Shaw, 2011; Ramsey-Klawsnik et al., 2007; Rosen et al., 2010). These studies indicate that ESA can occur either at home or in institutions (Ramsey-Klawsnik, 2004; Ramsey-Klawsnik et al., 2007; Teaster & Roberto, 2004b). When the abuse occurs at home, 81% of the perpetrators are the caregivers: spouses, other family members, or a paid caregiver. When the abuse occurs in institutions, the perpetrators can be either residents or staff members (Iversen et al., 2015; Ramsey-Klawsnik et al., 2007).

ESA can occur as a continuous and ongoing pattern from the younger life stage, in cases of life-long IPV (Teaster, Roberto, & Dugar, 2006), in which sexual abuse represents only one form of the abusive behavior in spousal relationships (Capaldi, Knoble, Wu Shortt, & Kim, 2012). Comprehensive studies conducted in 10 different countries have suggested that between 6% and 59% of women experience sexual abuse by their partners at least once during their lifetime (Garcia-Moreno, Jansen, Ellsberg, Heise, & Watts, 2006). IPV goes together with the dynamics of control, and it occurs due to three factors: spouses' personal characteristics and childhood history, which might include sexual abuse, spousal relationship dynamics, and the general social construction (Abramsky et al., 2011; Tenkorang, Owusu, Yeboah, & Bannerman, 2013).

Another pattern of sexual abuse begins in old age. The physical and mental deterioration caused by the aging process affects men and women alike. Men's cognitive impairment (i.e., dementia) causes impulsive behavior and the lowering of sexual barriers (Ramsey-Klawsnik, 2004; Wharton & Ford, 2014). Women who are frail due to cognitive and physical deterioration might become dependent on their primary caregivers, who sometimes take advantage of the women's fragility and inability to object to or report sexual abuse incidents (Ramsey-Klawsnik, 2004; Teaster & Roberto, 2004b).

Finally, when sexual abuse occurs in institutions, the two most commonly identified perpetrators are staff (e.g.,

direct care providers and janitors) and, mostly, residents (Ramsey-Klawsnik et al., 2007; Rosen et al., 2010). The abusive residents are characterized by disabilities, including psychiatric illness or dementia, which impair their ability to self-regulate. Some have been prescribed medications that exacerbate impulse-control problems and increase libido, and others have criminal histories including sexual assault convictions (Bledsoe, 2006; Teaster et al., 2007). Women aged 80 years and above were more likely to be sexually abused and to suffer a range of sexually abusive behaviors, from sexual interest in the victim's body to forced intercourse (Burgess & Phillips, 2006; Ramsey-Klawsnik, Teaster, Mendiondo, Marcum, & Abner, 2008; Teaster et al., 2007).

Data on the prevalence of ESA is scarce (Malmedal et al., 2015). It was established that sexual abuse is the least frequently reported and substantiated form of elder abuse (National Center on Elder Abuse, 2006), and it is often categorized as physical abuse and not as a separate subcategory. Across studies, ESA prevalence ranged from 0.04% to 0.8% (Pillemer, Burnes, Riffin, & Lachs, 2016; Rosay & Mulford, 2017). In a study of older women who visited primary care clinics in Ohio, Fisher and Regan (2011) found that 46% experienced sexual abuse. The low prevalence indicates that, to date, ESA is not perceived as a social phenomenon. This attitude might be due to ageist beliefs that the older adult population is not sexually attractive and that sex is meant only for young people. Therefore, older people are not perceived as potential victims (Poulos & Sheridan, 2008). Professionals and members of the public are more likely to overlook sexual abuse than other types of elder mistreatment (Burgess et al., 2008; Teaster & Roberto, 2004b). Consequently, ESA is marginalized on the social and personal level.

Despite the fact that professionals in the health care system and the welfare and social services are centrally located in a position to identify and detect sexual abuse, it is likely that they are not sufficiently aware of ESA and probably lack the knowledge to identify cases (Alon, 2016). Therefore, we decided to examine the extent of professionals' awareness of the phenomenon and their encounter with cases of ESA. The aim of this survey was to map and gather preliminary information about ESA awareness among welfare and health care professionals who work with the older adult population in Israel. This survey can provide useful information for performing a further comprehensive inquiry into the phenomenon.

Method

Participants

The survey served as an exploratory study and was based on a convenience sample that consisted of 161 Jewish and Arab professionals (social workers and nurses) working with the older adult population in different welfare and health care systems (hospitals, municipal social services, and nursing homes) in Israel. Participants were recruited while participating in an external professional training program. They were told that participation was entirely voluntary, that the questionnaire was anonymous, was not related to their workplace in any way, and would have no impact whatsoever on their current employment.

Most participants (80%) were women. Their mean age was 43.6 years, the mean length of time at their job was 11.3 years, and specifically, 6 years was the mean length of time that had passed since their first encounter with elder abuse at work. Of the participants, 112 (70%) were Jewish and the other 49 (30%) were Arabs, representing the ratio between the Jewish and Arab populations in Israel. Eighty-one participants (50%) out of the entire sample were professionals who worked in social services, and the other 50% worked in health care organizations.

Instruments

A basic questionnaire was designed specifically for this survey, including demographic data and six questions regarding ESA. Questions addressed (1) the extent of the encounter with ESA, (2) the victim's gender, (3) the offender's identity (e.g., family member, spouse, or paid caregiver), (4) how the case was disclosed to the professional, (5) type of sexual abuse, and (6) the intervention chosen by the professional (see the appendix). The questionnaire was reviewed by experts in the field of elder abuse and neglect and was tested in a focus group of professionals.

Procedure

The university committee for ethical research with humans approved the survey. The questionnaires were handed out to the participants by one of the researchers during training programs held in different places in Israel. As mentioned above, participation was completely voluntary. All questionnaires were anonymous and self-administered. They took between 10 and 15 minutes to complete, and were collected in a sealed envelope that had been distributed with the questionnaire.

Data Analysis

Before using the questionnaire, reliability was tested and the internal consistency reliability coefficient (Cronbach's alpha) was proven reliable ($\alpha = .73$). Data were analyzed in two phases, using SPSS statistic package. First, descriptive statistics were calculated. The relationship between the dependent variable, ESA, and the

Table 1. Participants' Encounter With ESA by Workplace.

	Participants' encounter with ESA		Total
Workplace	Yes	No	
Municipal social service	44	37	81
Nursing home	22	32	54
General hospital	5	18	23
Voluntary association	0	3	3
Total	71 (43%)	90 (57%)	161 (100%)

Note. ESA = elder sexual abuse.

Table 2. Reporters' Identity by Workplace.

	Reporter			
Workplace	Victim	Family member	Paid caregiver	Other
Social services	30	6	4	4
Nursing home	18	2	2	0
General hospital	2	2	1	0
Total	50 (70%)	10 (15%)	7 (10%)	4 (5%)

Table 3. Types of ESA by Frequency.

Type of sexual abuse	Number of cases	Frequency (%)
Sexual assault or rape	45	64
Indecent assault by another family member (son)	14	20
Verbal sexual abuse	10	14
Sexual abuse in the past (not in the present)	2	2
Total	71	100

Note. ESA = elder sexual abuse.

independent variables (age, workplace, and practice experience) was examined. Second, Pearson correlation was performed to find correlations between variables.

Results

Descriptive statistics are presented in Tables 1 to 4. These tables show the prevalence of the encounter with ESA and the distribution according to ethnicity, workplace, age, and professional experience. In terms of the degree of professionals' encounter with ESA, results show that 43% of the professionals encountered ESA. Half of the Jewish participants (50%) had encountered at least one to three cases of ESA, whereas among the Arab participants, only 37% had encountered this number. A total of 98% of the victims were women, and the primary offender was the spouse (75%). In most cases (70%), the victim reported the abuse, which was mainly sexual assault (75%). All participants (100%) noted that action was taken. In most cases, this entailed discussing the issue with the family or the couple and obtaining a restraining order in extreme cases.

Table 1 presents participants' encounter with ESA by workplace. Results show that only 71 professionals (43% of all participants) encountered ESA, whereas 90 (57%) reported that they had not encountered cases of ESA. Most of them (62%) worked in municipal social services, and 31% worked in nursing homes. Only five professionals (7%) from general hospitals encountered cases of ESA. Workers in the nongovernmental organization association had not encountered cases of ESA.

Data in Table 2 present the reporters' identity according to workplace. Findings indicate that most of the reports (70%) were made by the victim, of which 30 (60%) were reported in municipal social services and 18 (36%) were disclosed by the victim in nursing homes. The second most common reporter was a family member (15% of the reports).

Table 3 presents frequency of types of sexual abuse. Data indicate that sexual assault or rape were the most

Table 4. Types of ESA by the Identity of the Offender.

Type of sexual abuse	Offender's identify	Number of cases	Percentage
Sexual assault (*N* = 45)	Spouse	45	100
	Other family member	0	
	Paid caregiver	0	
	Institutional staff member	0	
Indecent assault (*N* = 14)	Spouse	3	22
	Other family member	7	50
	Paid caregiver	2	14
	Institutional staff member	2	14
Verbal sexual abuse (*N* = 10)	Spouse	3	30
	Other family member	4	40
	Paid caregiver	2	20
	Institutional staff member	1	20
Sexual abuse in the past (not in the present; *N* = 2)	Spouse	2	
	Other family member	0	
	Paid caregiver	0	
	Institutional staff member	0	

Note. ESA = elder sexual abuse.

common types of ESA (45 cases and 64%, respectively). Among the other ESA types, 14 cases (20%) of indecent assault were reported and 10 (14%) cases of verbal sexual abuse.

Table 4 presents the type of sexual abuse by identity of the offender. As shown in the table, male spouses were the main ESA offenders in all types of sexual abuse, including verbal sexual abuse. Other family members, particularly sons, were the main offenders in cases of indecent assault (66%).

Finally, to learn if any relationships exist between the dependent variable, ESA, and the independent variables age, workplace, and practice experience, Pearson correlation was performed. Results showed (1) a strong and positive correlation between practice experience and professionals' encounter with ESA ($r = .81$), (2) a positive but not so strong correlation between age and professionals' encounter with ESA ($r = .6$), and (3) a positive and strong correlation between workplace and professionals' encounter with ESA ($r = .7$). Significance was declared at $p < .05$.

Discussion

The aim of this survey was to explore professionals' awareness of sexual abuse in late life. The results support findings of the small number of previous studies conducted on this topic (Fileborn, 2016; Malmedal et al., 2015; Ramsey-Klawsnik, 2004; Ramsey-Klawsnik et al., 2007; Rosay & Mulford, 2017).

The first significant finding was that less than half (43%) of the professionals who participated in our survey had encountered ESA and those who had (82%) had encountered between one and three cases. The low rate of reported cases can probably be explained by the professionals' lack of familiarity with the ESA phenomenon, which is still widely considered taboo (Iversen et al., 2015). The professionals in the current survey received 70% of the reports on ESA from the victims. Nevertheless, many victims probably either did not or could not report the abuse because of fear, shame, or cognitive deterioration. We suspect that the actual number of cases is higher, which would indicate that awareness of ESA is in its initial stages. A similar process occurred in exposing the domestic violence phenomenon, such as IPV about 40 years ago (VanderEnde, Yount, Dynes, & Sibley, 2012). Comparable findings on elder abuse were presented in studies from 30 years ago, before it was recognized as a phenomenon. Due to the small number of cases reported by professionals at that time, it was assumed that the phenomenon had been underreported (Pillemer & Finkelhor, 1989).

Consistent with previous literature, most of the victims (98%) were found to be women, and most of the offenders were their spouses (Capaldi et al., 2012; Garcia-Moreno et al., 2006). An additional finding was that ESA in the form of sexual assault, which involves physical contact, was the most common type of abuse (64%) reported by professionals in the current survey. This also goes hand in hand with the fact that ESA is presently at an initial stage of recognition as a health and social problem. Therefore, professionals tend to be influenced more by visible abusive behaviors, such as physical harm, sexual assaults, and intentional insult, than invisible forms of abuse (Alon, 2004).

Another important finding is that most of the ESA reports (70%) were made by the victims themselves. The

assumption is that the majority of those reports were submitted by women living in long-term IPV relationships, and the sexual abuse was part of the complex intimate relationship, as mentioned by other researchers (Band-Winterstein & Eisikovits, 2014). This assumption can be supported by the fact that 63% of the encounters were by social workers working at municipal social services (see Table 1). Hence, it can be assumed that victims were treated by social workers. In addition, the fact that most of the reporters were victims raises the question of awareness of the victim's abuse among close social circles, such as family, neighbors, and caregivers. This question is extremely important in cases of cognitive decline, which limits the victims' ability to report the abuse, and increases their vulnerability (Ramsey-Klawsnik et al., 2007; Wharton & Ford, 2014).

An additional finding refers to cultural differences, expressed by the difference in rates of encounter with sexual abuse in Jewish and Arab societies. Jewish participants were probably more aware of ESA than their Arab counterparts and therefore reported more frequent encounters with the phenomenon (Lowenstein, Eisikovits, Band-Winterstein, & Enosh, 2009). It is also possible that more Jewish clients felt comfortable to report ESA because their cultural background encourages openness and disclosure of such phenomenon. This finding raises several questions, such as the following: Do Arab victims report less abuse because of the conspiracy of silence that characterizes traditional societies (Higgins, Zheng, Liu, & Sun, 2002)? Is the low rate of encounter with ESA a consequence of the Arab professionals' low level of awareness of the ESA phenomenon? Is it a reflection of cultural and social constructions of sexism, which exist in traditional societies (Burgess & Clements, 2006; Osgood & Manetta, 2003)? Or might cultural barriers, such as elder sexuality as a taboo (Malmedal et al., 2015), combined with social perceptions of older women's sexual needs in a conservative and patriarchal society, impact professionals' awareness? Most of the existing knowledge on sexual abuse in cultural contexts refers to younger women. For example, immigrant Latina women reported difficulty in disclosing their sexual victimization due to cultural norms that present them as their partners' possessions, in general, and in the context of sexual relationships, in particular. Consequently, these women experienced themselves as criticized and blamed by society for seeking help (Ligiéro, Fassinger, McCauley, Moore, & Lyytinen, 2009). As for the Arab society that endorses patriarchal values (Zaatut & Haj-Yahia, 2016), disclosing sexual abuse might also lead to condemnation and even to excommunication of female victims. Thus, their major fears stem from the belief that revealing the sexual abuse might result in loss of familial and social support, loss of self-respect, and inability to guarantee a normal life in the future (Shalhoub-Kevorkian, 1998). However, to the best of our knowledge, the intercultural context of ESA has not been sufficiently addressed to date. Hence, the aforementioned questions call for further research in this sensitive area.

Finally, it is worth noting the finding regarding the strong positive correlation between the workplace and encounter with ESA ($r = .7$). Another positive and strong correlation was found between practice experience and encounter with ESA. It can be assumed that working in social services provides access to a wide range of older adults and more opportunities to encounter older victims of sexual abuse. We can also assume that the more experienced the workers are the more cases of ESA they encountered. The greater confidence and skill gained through this experience might lead to more ability to cope with this sensitive issue. The same applies to age and ESA. Age can be linked to personal maturity and the ability to deal with this abusive phenomenon.

Limitations

The aim of the current survey was to examine and assess the extent of professionals' encounter with the ESA phenomenon. Despite the fact that the survey is not a national study based on a random and representative sample, but based on a convenience sample, the findings suggest that professionals encounter the ESA phenomenon to some extent. We are aware of the fact that the use of a convenience sample limits the possibility to generalize and draw comprehensive conclusions. However, it should be emphasized that this is the first exploratory survey in this field in Israel. These findings do indicate the existence of ESA and have direct implications for practice and research.

Implications and Recommendations

Elder sexual abuse recognition can be promoted through raising awareness among health care and welfare professionals whose work brings them into daily contact with the older adult population. They are responsible for assessing potential victims for injuries and mental and emotional distress. Professionals need screening tools for proper detection of physical, emotional, and behavioral changes in older adults, which might indicate an experience of sexual abuse (Iversen et al., 2015; Trevillion, Agnew-Davies, & Howard, 2013). Screening and detection could be followed by collaboration with multidisciplinary teams, such as helpline volunteers and forensic medical examiners, to design comprehensive intervention programs (including protection and separation from the offender) and to address psychological, health, legal, and forensic aspects of sexual abuse, thus empowering victims (Baker, Francis, Hairi, Othman, & Choo, 2016).

Due to the fact that elder abuse and neglect in general and ESA in particular are considered taboo (Iversen et al., 2015) and occur behind closed doors, professionals have difficulty detecting and reporting cases of ESA. Developing training programs for professionals is recommended to increase their awareness and provide them with knowledge and skills to detect, report, and intervene with ESA, including the use of forensic services in this context. We suggest creating peer discussion groups in workplaces for consultation and decision making regarding legal and ethical issues, which stem from the obligation to report and to plan directions for employing strategies in order to deal with ESA. A supportive work environment can encourage a discourse to cope with difficulties, barriers, and ethical dilemmas that arise in the course of dealing with ESA.

On the policy-making level, clear-cut policies and reporting systems are essential to address ESA appropriately (Iversen et al., 2015). Comprehensive research is recommended to investigate the extent of the problem, its characteristics, and the various dimensions of ESA in the community and in long-term care settings. In addition, due to the paucity of current knowledge on cross-cultural differences relating to ESA and professionals' awareness of the phenomenon across cultures, it is essential to examine sociocultural differences regarding ESA in general, and modes of coping with it in particular. All of these will undoubtedly contribute to preventing and/or reducing the harm caused to older adult victims of sexual abuse.

Appendix

The Survey Questionnaire

Dear Participant,
After years of work in the field of gerontology, we have learned that professional discourse about elder sexual abuse (ESA) is limited. As part of a survey aimed at mapping the ESA phenomenon, we ask you to kindly express your consent and respond to the attached questionnaire. The questionnaire is anonymous. It is not related to your workplace in any way and has no impact whatsoever on your current employment. Your responses to the questionnaire can contribute to the understanding and deepening of the knowledge regarding ESA.

Questions

1. **In the past 12 months, have you encountered cases of elder sexual abuse during your work?**
   No____ Yes____
   If you answered yes, how many cases have you encountered?
   0-3
   3-5
   5-10
   10+
2. **How did you find out about the case?**
   From the victim____
   From a family member_____
   From a paid caregiver_____
   Other_____
3. **Of the cases that you encountered, against whom was the injury directed?**
   Against a male older adult_____
   Against a female older adult_____
4. **Who was the perpetrator?**
   Spouse____
   A family member____
   A paid caregiver_____
   A professional_____
   A staff member in a long-term institution_____
5. **How was the sexual abuse manifested? Please describe:** _____
   _____
6. **Have any steps been taken in relation to those cases?**
   No____ Yes____
   Can you give details? _____
   _____

Personal Information
Gender____
Age____
Years of experience in the field of gerontology_____
Years of experience in the field of elder abuse and neglect_____
Ethnicity: Jewish_____ Arab____ Other_____
Organizational affiliation:

Hospital____
Social welfare agency____
Nursing home (long-term care institution)____
NGO_____
Other_____

Thank you for your cooperation!

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Author Roles

Sara Alon and Niva Tuma conducted the data collection for the survey. Sara Alon, Tova Band-Winterstein, and Hadass Goldblatt planned, drafted, and wrote the Introduction and Discussion sections of the article, as well as reviewed and revised the entire article. Niva Tuma conducted the data analysis and drafted the Method and Results sections. All authors are responsible for the article's content.

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