The status and wellbeing of older people has received considerable attention in recent months. Federal reforms for reporting elder abuse in aged care settings were announced in July 2006 (as discussed in Aware 13, see Quadara, 2006), and more are pending. Furthermore, the International Day of Older Persons (1 October) and more locally based events, such as the Victorian Seniors’ Festival, have drawn further attention to the issues that face an ageing population, including those of violence and abuse.

But how does the violence experienced by older people intersect with gender? As many researchers have noted, it is important to understand how violence against older women, in particular sexual assault, is connected to gendered violence experienced over the lifespan. For many women, the dynamics of what may be termed ‘elder abuse’ and previous sexual violence has much in common. In this article, we consider the research on the nature and impact of sexual assault against older women, and suggest implications of this for responding to older women as victim/survivors of sexual assault.

The prevalence and nature of sexual assault against older women

Much research on the prevalence of sexual assault notes that little attention is paid in the empirical literature to women over the age of 50. Ball, 2005; Del Bove, Stermac, & Bainbridge, 2005; Elder, 2000). The results of the Personal Safety Survey (see article in Aware 13 by Morrison, 2006) show that Australian women of all ages experience sexual assault—it is not limited to younger women. However, it is often unclear what the age distribution over 45 is, and what the nature of the sexual assault is. The British Crime Survey (Kershaw, Chivite-Matthews, Thomas, & Aust, 2001) found that of sexual assault victims, 0.6% were over 50. A smaller study in Canada (Del Bove et al., 2005) compared the sexual assault of 61 women between 55 and 87 years with two other age groups (31–54 years and 15–30 years). Data on the nature of the assault, the degree of coercion, and injuries sustained were gathered from a database of clients presenting at a hospital-based Sexual Assault Care Centre. The researchers found that sexual assault against women in the 55–87 group (the mean age was 65) shared many characteristics with the assaults against the younger groups. Specific findings were that women in the oldest group:

- were just as likely to experience severe methods of coercion such as physical violence and restraint as the two younger groups;
- were just as likely to be assaulted by an acquaintance as by a stranger; and
- sustained similar injuries, including soft tissue damage (for example, bruises) and lacerations, but sustained slightly higher rates of vaginal injuries than younger women.

The similarity of sexual assaults across the age groups surprised the researchers and is at odds with much of the other literature, which suggests that older women are more likely to be sexually assaulted by strangers (Del Bove et al., 2005). This similarity is especially significant given the data used. The Sexual Assault Care Centre is part of a larger emergency crisis unit. It is likely that many victim/survivors of sexual assault who are older than 50 have not reported their assaults.
survivors of sexual assault would not present at an acute service such as this, particularly in instances where sexual assault is part of an ongoing or interpersonal relationship. In other words, sexual assault against older women by intimates might be more prevalent than this study suggests. In addition to these similarities, a range of particular differences were shown. For example, older women were more likely to be living on their own and least likely to report supportive friendships. However, 15% of the women were living in a group setting, which the researchers suggest could mean a residential or institutional home (Del Bove et al., 2005). As well as these differences, the research found that there was a higher rate of cognitive disability among the older women, a quarter of older women were accompanied to the centre by ambulance, and they were more likely to be assaulted in their own homes in comparison to the other two age groups of women.

The similarities and differences shown in this research point not just to the particular vulnerabilities of older women, such as social isolation; they also point to the fact that the characteristics of sexual assault against older women do not differ by virtue of age (Del Bove et al., 2005). Women from the age of 15 to 88 appear to experience the same forms of assault (i.e., sexual penetration) and similar levels of violence and injury; what changes is the context. These findings indicate that sexual assault is not just a ‘young women’s issue’.

**Sexual assault as part of elder abuse**

While the research by Del Bove et al. points to a continuity in experiences of sexual assault across the ages, there is a tendency in much of the research for older women to “drop off the radar”; there is a lull or gap in knowledge about older women and sexual assault. Where sexual assault emerges again is in the context of ‘elder abuse’.

Research in this context has found that in many cases, women continue to experience violence and abuse at higher rates than men. A Curtin University of Technology study estimated the prevalence of elder abuse of women in Western Australia to be two-and-a-half times that of men (Boldy, Webb, Horner, Davey, & Kingsley, 2002)—a finding replicated in other studies (Faye, 2003; Roberts, 1993; Sadler, 1993). The study by Boldy et al. also found that:

- material/financial abuse accounted for 81% of known incidents, followed by psychological abuse (55%) and physical abuse (32%);
- 43% of perpetrators were the victim’s children, with sons and daughters being equally represented; and
- spouses or other relative accounted for 35% of perpetrators.

Another Western Australian study (Faye, 2003) found that the majority of incidences of elder abuse occurred in the victim’s home (87%). At the outset, then, gender differences are evident: women remain more likely to experience abuse at the hands of care providers, family members and other trusted individuals. The dynamic of elder abuse is therefore similar to other forms of interpersonal violence women experience—it occurs in the private domain, among family members and is complicated by various forms of dependency (perhaps the older person lives with the family and depends on them for financial security, physical mobility, etc.).

Although sexual assault makes up about 3% of known cases of elder abuse in care facilities, research suggests that women are overwhelmingly the victims in situations of elder sexual abuse. One of the first studies on sexual assault against older women, conducted in Massachusetts, found that, of the 28 cases examined, all victim/survivors were women, all but one of the offenders was a man and the majority of offenders were caregivers to the victim/survivors (Ramsey-Klawsnik, 1991). A study
conducted in the UK also found that 86% of victim/survivors of elder sexual abuse were women, and in 98% of cases the offenders were male (Holt, 1993).

These studies are indicative of the fact that although elder abuse may take many forms, sexual assault of more elderly women resembles the pattern of sexual assault generally: an overwhelming proportion of victims are women who experience violence at the hands of family members or those in positions of trust.

So how well does the term ‘elder abuse’ encompass women’s experiences of violence, not just at particular points in their lives, but over the lifespan?

**The prevalence of sexual violence over the lifespan**

Older women experience sexual violence at significant rates, and this continues beyond the age of 65. Sixty-five is an age nominally seen to transform ‘women’ into ‘old’; that is, if a woman experiences sexual assault over 65, it is viewed as an issue of age rather than gender. It is therefore becoming increasingly important to consider the prevalence of sexual violence not only in certain age categories, but over the lifespan. This is an area of increasing interest to service providers, clinicians and researchers.

Research conducted in the US highlights the ongoing, persistent, and epidemic quality of violence against women: 1 in 5 girls are sexually abused (peaking between 8 and 12 years old); in adulthood, 1 in 4 women are raped (peaking between the ages of 18 and 24); intimate partner violence affects 1 in 5 women (most likely between the ages of 24 and 32); pregnancy has emerged as a factor associated with physical and sexual violence, with 1 in 6 pregnant women being assaulted; and 1 in 20 women over the age of 60 experience ‘elder abuse’, a likelihood that increases with age where victims are more frail or vulnerable (Filtcraft, 1995).

In a longitudinal Melbourne-based study of middle-aged women, 362 women between the ages of 51 and 62 completed a questionnaire regarding their experience of physical, sexual and emotional violence (Mazza, Dennerstein, Garamszegi, & Dudley, 2001). The study found that, overall, 28.5% of women had experienced some form of violence (physical, sexual or emotional) over their lifetime, 11.6% had experienced rape or attempted rape since the age of 16, and 5.5% had experienced severe physical abuse in the last 12 months. Similar findings were generated by a US study (Stein & Barrett-O’Connor, 2000) of 533 women between the ages of 50 and 80 (where the median age was 75), of which 12.7% had experienced sexual assault. Of these women, more than a fifth said they had experienced sexual assault repeatedly over the course of their lifetimes.

These findings are also reflected in qualitative studies with older women for whom sexual violence is an enduring part of their lives, in their relationships with fathers, husbands and sons (Duncan, 2006; Elder 2000; Mears, 2002; Olle, 2005; Pritchard, 2000). Often, the trauma of the experience was not fully felt until women were in their 40s and 50s (Elder, 2000, p. 21), and in some instances, the women had not disclosed that sexual violence had occurred until 40 years later (D’Arcy, 1999).

In light of women experiencing multiple instances of victimisation, sexual abuse in childhood, sexual assault as a teenager and intimate partner violence (including sexual assault) over many years, Hightower et al. (2001) questioned whether the focus on age, rather than on the act or relationship between perpetrator and victim, creates artificial divisions in the identification of violence against women. In other words, ‘elder abuse’ can truncate the recognition that rape of older women is part of a continuum of violence over the lifespan.
The importance of recognising the continuum of gendered violence

It is difficult to know the true extent of sexual assault against older and elderly women. Firstly, very little research has been done specifically around the issue of sexual assault among the elderly; as Pritchard (2000) described, it is regarded as a ‘taboo topic’ and ‘incredibly difficult’ to detect (p. 4). Secondly, where it is detected, this is often through intervention into other forms of abuse, such as physical abuse or neglect (Quinn, 1994). In addition, physical, cognitive and communication impairments can make disclosure of sexual assault difficult. Finally, when it comes to community perceptions of what actually constitutes elder abuse, it appears that sexual assault barely figures. An ACT study found that, when asked what elder abuse referred to, respondents commonly stated ‘physical’ and ‘psychological’ abuse. Only 3% of respondents referred to sexual assault. In short, the extent and nature of sexual assault as a form of elder abuse is difficult to determine. For many working in the area of sexual assault prevention and service provision, this is further compounded by using the term ‘elder abuse’ to describe the sexual and physical violence experienced by older women.

The definition of elder abuse can be broad. The Victorian Government defined elder abuse as:

Any act occurring within a relationship where there is an implication of trust, which results in harm to an older person. Abuse may be physical, sexual, financial, psychological, social and/or neglect. (Office of Senior Victorians, 2005)

In their submission to the Victorian Government’s elder abuse prevention policy, the Centre Against Sexual Assault (CASA) observed that no population studies existed in Australia that compared rates of violence experienced by men and women across their lives. This has only recently been examined in the Personal Safety Survey (Australian Bureau of Statistics, 2006). CASA’s report, Older women’s experience of violence (Elder, 2000), argues that it is important that ‘elder abuse’ does not conceal violence against women; neither domestic violence nor sexual assault should become redefined as ‘elder abuse’ simply by virtue of the victim/survivor turning 65. In the study, CASA observed that the term ‘elder abuse’ is both broad and gender-neutral; yet at the same time, there is little information about the nature and impact of violence against older women.

It is important to question how the adoption of the terminology of ‘elder abuse’ can conceal the structural, socially embedded nature of women’s experience of violence. The term ‘elder abuse’ can make it seem as though “there is something inherent about the situation, context or relationship that evokes, provokes, explains and justifies the violence and abuse” (CASA House, 2005, p. 2). Analyses of, and adequate responses to, older women’s experience of violence “must recognise the gendered nature of that experience” (Elder, 2000, p. 9).

Recognising key issues for older women as victim/survivors of sexual assault

Older women who are victim/survivors of sexual assault face a unique set of issues that can make disclosure and healing particularly difficult. A survey of the current literature suggests the following as major elements in recognising how sexual assault impacts upon older women.

The ‘triple jeopardy’ of older women

In addition to acknowledging the experience of sexual violence throughout the life cycle, it is essential to also take into account the particular position of older women as victims of sexual assault. It is recognised that the “combination of ageism, sexism and the view that the family is a caring unit that should not be interfered with, makes the task of recognising when older people are being abused, a very difficult one” (Mears, as cited in Duncan, 2002, p. 5). In addition, social values and attitudes around the issues of marriage, gender
roles and expectations, and violence in families for women born before 1950 can make both disclosing sexual assault and accessing services difficult (Duncan, 2002, pp. 14–16).

In the qualitative research available, women spoke of staying “40 years in a [sexually violent] marriage. ‘I thought that’s how it was’” (Elder, 2000, p. 23); the inappropriateness of going outside the family for assistance; the inability of GPs at the time to adequately respond: “the doctor would only have given me Valium” (Elder, 2000, p. 19); and the fear of the consequences of disclosure, since in many cases women’s partners controlled finances or would use children as a coercive factor. These barriers are exacerbated for women from non-English speaking backgrounds (Ana-Gatbonton, 1999). Ana-Gatbonton identified language barriers, the impact of immigration (grief, loss and fear at relocating to another country), refugee experiences, and traditional cultural norms that require women’s obedience to the family as fostering a sense of social and cultural isolation for older women experiencing sexual assault.

Difficulties in accessing sexual assault services

Women of all ages and for a variety of factors find it difficult to share experiences of sexual assault. This is exacerbated for older women. Indeed, none of the 102 women interviewed for the CASA report on older women used a service following a sexual assault (Elder, 2000). The reasons given by the women as barriers to access included financial dependence, a lack of response after telling GPs or police, rural isolation, a sense that no-one would appreciate their situation, expectations about marriages in which women were expected to ‘keep quiet’ and stick with bad marriages, being unaware of the available services, and not feeling entitled to access services. For women from linguistically diverse backgrounds, information regarding sexual assault against older women and legal/support avenues for older women who have experienced sexual assault is not communicated in targeted multilingual ways and inhibits women from saying anything about their experiences.

Health impacts of violence over the lifespan

There are two important things to acknowledge here. The first is that sexual violence that is experienced over the lifespan (which is often also experienced alongside other forms of violence such as intimate partner violence, stalking or harassment) has long-term impacts upon the mental and physical health of victims/survivors. This can take the form of arthritis and rheumatism, gastro-intestinal problems, increased risk of breast cancer (Stein & Barrett-O’Connor, 2000), anxiety, depression, changes in eating habits, panic attacks, alcohol and drug use, and sleep disturbance (Olle, 2005).

The second point is that the health issues of older women can be misattributed to ‘ageing’, rather than to violence over the course of one’s life (Olle, 2005, p. 35). For example, in Stein and Barret-O’Connor’s study (2000), they found that 1 in 5 women were taking a thyroid hormone for thyroid disease, suggesting, in their words, “overdiagnosis and presumptive treatment of malaise, ‘tiredness’ or weight-gain”. They warn that this misclassification could obscure any true association with sexual assault. To extend their warning, it is likely that a range of physical and mental health issues that bring women to GPs and other health professionals have an association with experiences of violence, both in the past or more recently, or in an ongoing way. If lifetime experiences of violence are not brought to the forefront of research on sexual violence, and if classificatory ‘silos’ such as ‘elder abuse’ sever these connections over time and space, then not only will the health impact of sexual violence remain under-examined, but women will also not receive the most adequate and productive health care.
Responding to older women’s experiences of violence

It is important to recognise both women’s shared experience of sexual violence over the course of their lifetimes, and the particularities of women’s circumstances. Stages in the lifespan are part of this. As McCreadie noted of the available literature: “the domestic violence literature has barely concerned itself with older people, and the elder abuse literature has barely concerned itself with domestic violence” (as cited in Mears, 2002, p. 2). In her study of older women’s experience of domestic violence, Mears highlighted the conceptual difficulty of using the term ‘elder abuse’ to define interpersonal violence. Through her interviews, Mears engaged with the ‘living ethnographic material’ of how women give meaning to the sexual and domestic violence they experienced: “when women began telling their stories, it became clear that they saw and experienced their lives as a continuous whole, and so using an arbitrary ‘cut off’ age in regard to the age at which the violence occurred, was just not appropriate” (p. 4).

There is a danger that the terminology of ‘elder abuse’ will obscure the continuous way in which older women experience sexual assault. This does a significant violence to how older victim/survivors make sense of, and tell others about, their experiences. In addition, there is a danger that defining ‘elder abuse’ as something that happens ‘after 65’ will perpetuate the gap in knowledge of which McCreadie wrote (as cited in Mears, 2002). An overarching theme in the qualitative research with older women as victim/survivors of sexual assault is the importance of recognising and responding to their stories as stories of violence against women, rather than stories of ageing and vulnerability.

References


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