Rape and serious sexual assault against women aged 60 and over

BOWS, HANNAH

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Hannah Bows

Abstract

Despite the vast amount of research attention examining sexual violence against women, and an increase in research around abuse of older people over the last two decades, sexual violence against people aged 60 and over remains under-researched. As the world population continues to rapidly age, there is a pressing need to address this gap in research in order to inform policy and practice in preventing and responding to sexual violence. This thesis contributes to three existing, but currently distinct, fields of inquiry: elder abuse; domestic violence against older women; and sexual violence against older women. A multi-methodological multi-stage approach was adopted to examine the extent and nature of sexual violence against older women in the UK and the characteristics of victims, perpetrators and incidents through analysis of police data gained through Freedom of Information requests. Interviews with 23 practitioners working in sexual violence organsiations and 4 working in age-related organisations shed light on some of the challenges older survivors may experience when accessing support services, the key support needs of older survivors and the extent to which practitioners felt comfortable in meeting those needs. Gaps in current service provision were also explored. In the final stage, three women survivors of sexual violence since the aged of 60 shared their stories, in particular the physical and emotional impacts sexual violence had on the and providing accounts of their experiences of accessing support services. Their thoughts on issues with current support provision and existing gaps were also shared. This thesis considers these findings collectively to examine for the first time the extent, nature and impacts of sexual violence against women aged 60 and over.

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Hannah Bows

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Signed: 

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Chapter 1: Introduction

There has been a global explosion of research examining sexual violence over the last four decades. Sexual violence is now recognised as a serious public health problem and violation of human rights, affecting millions of people around the world, with international data consistently revealing women to be the vast majority of victims. Research, policy and practice have developed since the second-wave women's movement in the 1970s where it was placed at the top of the feminist agenda. At the same time, abuse of 'older' people (commonly referred to as elder abuse) has been of increasing interest to researchers and policy makers over the last two decades, in part reflecting the rapidly ageing world population. Furthermore, domestic violence against older people, predominantly women, has attracted research and policy attention over the last decade. However, sexual violence against older people has, to date, been largely absent from developments in all three areas. Whilst this has not gone unnoticed, (Ball, 2005; Jeary, 2005; Jones and Powell, 2006; Whittaker, 1995) there remains a lack of effort to examine this area. Sexual violence against older people sits awkwardly between the elder abuse and domestic violence developments and has been described as one of the last taboos in society (Jones and Powell, 2006).

This chapter draws together the background to this mixed-method doctoral study, which investigated the extent, nature, and impacts of serious sexual violence against people aged 60 and over. It begins by outlining the rationale, the aims and the research objectives which guided the research. This chapter then provides the theoretical framework, which underpinned the research, rooted in feminist theory but drawing from gerontology and intersectionality theories. The chapter then goes on to describe some of the problems with the definitions used across the existing research and the

terminology adopted in this thesis. It then contextualises the research by outlining the invisibility of sexual violence against older people, the ageing population and the prevalence of 'real rape' stereotypes, which are argued to contribute to the lack of awareness of sexual violence in later life. This chapter concludes by outlining the structure of the thesis.

1.1 Rationale, aims and research objectives

Despite the growing research and policy interest in preventing and addressing sexual violence and an equally growing interest in abuse of older people (often referred to as 'elder abuse') the intersection of sexual violence against older people has been largely ignored. Research suggests that younger women are at an increased risk of sexual violence (McGee *et al*., 2002; Hanly *et al*., 2009; Home Office, 2013) and consequently the majority of research attention has focused on younger women. In some cases, for example the Crime Survey for England and Wales (CSEW), older people have been explicitly excluded (Myhill and Allen, 2002). Furthermore, law, social sciences and health and social care disciplines have marginalised older women in sexual violence research (Jones and Powell, 2006). Some have gone as far as to argue that the reluctance by feminists to examine sexual violence against older women equates to a form of rape denial (Jones and Powell, 2006, p.215).

Three empirical studies have been conducted in the UK in the last two decades (Jeary, 2005; Ball and Fowler, 2008; Lea *et al*., 2011) and one in Ireland (Scriver *et al*., 2013), all of which are quantitative in nature and with a primary focus on estimating the prevalence of rape or sexual assault against older women (Ball and Fowler, 2008; Scriver *et al.*, 2013) or examining the characteristics of the assaults, victims and perpetrators (Jeary, 2005; Lea *et al*., 2011, Scriver *et al*., 2013). The only study to include a qualitative element was Scriver *et al*. (2013), which included two case studies of survivors

accessing rape crisis centres in Ireland, which included interviews with the survivors. The focus of the two interviews was to compare the differences in those reporting historic and those reporting more recent assaults and to explore the perceptions of abuse and reasons for accessing/not accessing services.

Several commentators have noted the methodological limitations with these studies, including small samples drawn from single police force areas or focusing on stranger rape cases (for an overview see Ball, 2005 and Mann *et al*., 2014). Crucially, to date there have been no studies which have utilised nationally representative data, nor has there been any qualitative studies in the UK or elsewhere that have interviewed older survivors about their experiences and the impacts of their victimisation and what support needs they present (Ball, 2005; Jones and Powell, 2006; Mann *et al*., 2014). As a result, there is a severe lack of understanding of the extent of sexual violence against older people and the impacts of sexual violence and service needs of this age group and how these can best be supported, which has significant consequences for both policy makers and practitioners (Jones and Powell, 2006).

This doctoral research aimed to build on the small pool of existing research in the UK and internationally, exploring both the prevalence and nature of sexual violence against older women through quantitative analysis of police data. It also examined the impacts and service needs of survivors and the extent to which these needs are being met with existing support services, through qualitative interviews with older female survivors and practitioners working in age-related and specialist sexual violence organisations. Whilst men were not excluded from the study, as women are victimised at significantly higher rates than men, the focus is on older women aged 60 and over. This mixed-method research sought to contribute to both an enhanced understanding of sexual

violence against older people, with a particular focus on women, and the development of policy and practice of specific age-related and sexual violence support organisations.

This study was specifically concerned with sexual violence that happens in later life, rather than historical sexual violence that is disclosed by older people. The main reason for this is based on the age cap of the Crime Survey for England and Wales (CSEW) and lack of research into sexual violence in later life. The guiding research objectives underpinning this mixed method study were: (1) To analyse the extent of police reported and recorded sexual violence against older people in the UK; (2) To examine the nature of sexual violence against older people, including victim, perpetrator and offence demographics; (3) To explore whether older women's experiences of sexual violence and the impacts differ from younger survivors' experiences; (4) To examine the factors that influence older survivors' decisions to report sexual violence to the police or support organisations; (5) To explore the support needs of older people who have experienced sexual violence since the age of 60 and (6) To explore whether staff and volunteers at specialist sexual violence organisations (e.g. Rape Crisis) and specialist age related organisations (e.g. Age Concern; Action on Elder Abuse) feel competent in their ability to meet the needs of older people disclosing sexual violence.

This research makes a valuable and original contribution to feminist criminology by incorporating older women's experiences into an area where they have been largely invisible. Older women have been almost exclusively absent from both feminist and criminological research and practice around sexual violence, and their experiences of sexual violence have been largely excluded from the gerontology research exploring elder abuse. The overlooking of older victims of sexual violence in both fields contributes to a dismissal of the problem.

1.2 The invisibility of sexual violence against older people in the UK

There are two main types of national data collection for sexual violence in England and Wales. The first is police recorded data which collects information on reported and recorded incidents of sexual violence. The second is the national victimisation survey, the Crime Survey for England and Wales (CSEW), which collects data on victimisation of most types of crimes, and since 2004/05 has included a self-completion 'intimate violence' module which collects data specifically on domestic and sexual violence (Thompson, 2010). As Smith (2006) notes, both the CSEW and police recorded crime statistics contribute to building up the national picture of crime trends and each approach has its strengths and weaknesses.

The latest statistics from the Home Office (2013), based on aggregated data from the 2009/10, 2010/11 and 2011/12 CSEW estimate around 2.5 per cent of women were a victim of rape or sexual assault in the previous 12 months. This equates to around 404,000 females, compared to 72,000 males. The data also reveals women aged between 16 and 19 experienced rape and sexual assault at a higher rate than any other age group. Furthermore, women who were single or separated were more at risk than women with different relationship statuses. Those with low annual incomes (less than £10,000) and students were the most at risk. In terms of victim-offender relations, for rape and sexual assault, over half (56 per cent) were raped by a partner or ex-partner. Studies examining police recorded data have drawn similar findings. For example, Feist *et al*. (2007) conducted an analysis of reported rapes in 2003/04 in England and Wales and found 86 per cent of rapes were perpetrated by a partner, ex-partner or someone else known to the victim. It is widely accepted that the majority

of rapes are committed by people known to the victim, in particular, partners, ex-partners or family members (Home Office, 2013).

There are significant differences between the CSEW data and police recorded data. For example, in 2011/12, the police recorded a total of 53,700 sexual offences across England and Wales. The most serious sexual offences of 'rape' (16,000 offences) and 'sexual assault' (22,100 offences) accounted for 71 per cent of sexual offences recorded by the police. This differs markedly from victims responding to the CSEW in 2011/12, the majority of whom reported being victims of other sexual offences (outside of the most serious category). This reflects the fact that victims are more likely to report the most serious sexual offences to the police and, as such, the police and broader criminal justice system (CJS) tend to deal largely with the most serious end of the spectrum of sexual offending. In terms of the most serious offences of rape or sexual assault by penetration, it is estimated that 0.5 per cent of women reported being a victim within the last 12 months. Furthermore, around one in twenty females reported being a victim of serious sexual offences since the age of 16 (Home Office, 2013). Of those respondents who said they had been a victim of a sexual offence, only 15 per cent stated they had reported the offence to the police, citing reasons including feeling embarrassed and not thinking the police could do much to help, for why they did not report.

Although the figures provided by the CSEW are a more accurate picture than police recorded data, they are still unlikely to provide an accurate picture of the extent of rape (Walby, 2004). Large-scale studies such as the CSEW and the Scottish Crime Survey are designed for more general purposes and therefore yield lower estimates of levels of violence against women than focused studies designed specifically for this purpose (Ellsberg *et al.*, 2001 cited in Fontes, 2004, p.149). Thus, although larger population-based studies may appear to have had advantages in terms of statistical precision, they

have tended to underestimate levels of violence and have therefore been less accurate than focused studies (Fontes, 2004, p.150).

There are therefore considerable methodological limitations with both police recorded data and that collected by the Crime Survey for England and Wales. Importantly for this research, one of the most under-acknowledged limitations of the CSEW is the upper age limit of 59. Although the general crime survey does not have an upper age limit, the intimate violence self-completion module, which collects specific information on sexual violence victimisation, has imposed a limit. The only justification for this is found in Walby and Allen's 2004 evaluation of the British Crime Survey (the predecessor to the CSEW):

> 'Although the BCS includes respondents aged 16 and over, the questions on interpersonal violence were only asked of those aged between 16 and 59. This was for two main reasons. First, older people have greater difficulty with or resistance to using a computer in this way. Secondly, it was thought that issues of elder abuse (from family members other than intimates) might get confused with responses about violence from intimates and that these issues were more appropriately dealt with in a specialised survey.' (Walby and Allan, 2004, p.118)

There are three main problems with this justification. First, the suggestion that older people are a homogenous group that is unwilling or unable to use a computer is underpinned by discriminatory ageist assumptions and stereotypes. In 2014, the average retirement age of women was 62.3 years (ONS, 2012) and research by the Office of National Statistics (2013) report the number of people aged 65 plus who have used the internet has overtaken those who have never used it. Moreover, such

myths have been dispelled by preliminary findings in an ongoing study which suggests older adults want to adopt modern technology and are happy and eager to embrace new devices and equipment (COBALT, 2013). The suggestion that people aged 60 and over are, in general, unable to or unwilling to use technology for the purposes of a survey also makes the presumption that all of those under this age would be fully able and willing to do so, in a way that those aged over 60 are not. Recently, the 2008/09 CSEW technical report described the results of a last trial to extend the age range to 69. It was reported that because a high proportion of respondents (around a quarter) requested help from the interviewer to fill in the self-completion that the age range should not be extended (ONS, 2015). However, the report reveals that around 16 per cent of people across all age groups required some assistance with the self-completion module, regardless of age, which is provided to them by interviewers, so it is unclear why this assistance cannot be provided to older people to enable them to complete the survey.

Second, the distinction between 'intimate violence' in the survey, which includes domestic violence and sexual violence, and 'elder abuse' is unnecessary. 'Elder abuse' encapsulates the same types of violence, such as sexual abuse, rape, physical and mental abuse which are contained in the definitions of rape and sexual assault under the Sexual Offences Act (2003) and the definition of domestic violence provided by the Home Office (2013). Therefore, distinguishing sexual violence experienced by older people purely on the basis of age is both unnecessary and ageist. It suggests a distinct type of violence is suffered by people because of, rather than in spite of, their age and carries assumptions and connotations of fragility, weakness and victim blaming (Whittaker, 1995; Wolf, 2000). Furthermore, it can be argued that re-categorising rape and sexual assault against older women as distinct from abuse of younger women is a form of linguistic euphemising which serves to gender neutralize, minimize and deny the realities of older sexual violence survivors (Romito, 2008).

The third issue is the suggestion that a specific survey on 'elder abuse' would be better placed to collect data on domestic and sexual violence against older people. As discussed above, the CSEW already collects data on sexual and domestic violence and therefore suggesting a different type of survey would be better placed to collect data on the experiences of people over a certain age is discriminatory and further marginalises older victims of sexual and domestic violence by treating them as distinct and different to other people whose experiences are valued in the CSEW. It explicitly suggests that sexual violence against older people, particularly women, is not the same as sexual violence against other (younger) women and again serves to re-categorise rape and sexual assault against older women as something to be treated by considering the age of the victim first. It is further problematised by the lack of elder abuse surveys conducted and the tendency to lump various forms of interpersonal violence under one section, typically 'physical violence' (Schiamberg *et al*., 2011) or 'intimate violence' which makes it difficult to elicit specific data from the results. Furthermore, some surveys have categorised these behaviours under a broad 'neglect and abuse' category, which again serve to minimize and neutralize the experiences by euphemising them into gender-neutral acts (Romito, 2008). As a result, there is little to no available data on the prevalence and characteristics of sexual violence against older women, or men, in England and Wales.

Until now, this justification has remained largely unchallenged in both the feminist and gerontological literature. Feminist theorists in general have been somewhat reluctant to provide gender-based analyses of elder abuse, argued by some on the basis that the gender-neutral concept means women are included as perpetrators (Whittaker, 1995), which thus complicates the gender-based power and inequalities argument which underpin many feminist perspectives (Neysmith, 1995). Moreover, it

has been argued that the failure to develop a gender-based analysis of elder abuse is actually fundamentally attributed to ageist attitudes within the feminist movement (Hightower, 2002).

1.3 A feminist gerontology theoretical framework

Although sexual violence can affect both men and women in later life, research has shown that women across all age groups are at a higher risk of victimisation than men and the vast majority of perpetrators, even against older victims, are male (Rosen *et al.*, 2010 and see Chapter 2). As such, the importance of gender cannot be overlooked and sexual violence in later life, as in younger populations, can be considered a form of violence against women. Consequently, although this research examined sexual offences against older people generally, including men and women, a feminist framework was considered appropriate as the majority of victims were women. Feminist theories have been at the forefront of sexual violence research and are relevant to this particular project due to their emphasis on both the individual and structural levels of multiple oppressions in a patriarchal society that may be experienced by women across the life course (Collins, 1986, p.214, 215; Browne, 1998, p.230). Consequently, rape has been argued to be a political act. As Griffin (1986, p.35) argues, rape is 'not an isolated act that can be rooted out from patriarchy without ending patriarchy itself'.

Research around rape and serious sexual violence has mainly focused on analysing the historical and social context of rape (Brownmiller, 1975) the prevalence of rape (Coid *et al*., 2003; Painter, 1991; Mooney, 1994, 2000) the reasons why men rape (Scully, 1990) impacts on survivors (Campbell, 2006) support needs and adequacy of services (Coy *et al*., 2011) 'success' of legislation and policies, and criminal justice approaches and responses to rape (Temkin, 2000; Ellison, 1998, 2001, 2005; Westmarland, 2004; Brown *et al*., 2010). In particular, there has been a preference for qualitative

research, which has focused on listening to women's experiences and stories with a view to shaping responses and services (Oakley, 1981; Westmarland, 2001) following criticisms by some feminist scholars who argued that traditional quantitative methods were 'masculine', rigid and inappropriate for researching the experiences of gender violence against women (Oakley, 1974; 1981). Through listening to the voices of rape and sexual assault survivors, feminists have conceptualised rape as a manifestation of male abuse of power (Buchanan and Jamieson, 2016). However, feminist theories have been criticised for failing to consider how other characteristics and social factors contribute to the victimisation and experiences of women (Crenshaw, 2003), including age (Jones and Powell, 2006). Social gerontology and intersectionality provide theoretical frameworks that can address some of these gaps.

Phillips *et al*. (2010) describes social gerontology as an area of inquiry which has concentrated on the study of the social, economic and demographic characteristics of older people and an ageing population; however, in recent years the definition has expanded to include health, technology and overall lifestyle. Ash (2015) points out that, to date, the subject of elder abuse has generally been located within social gerontology in family violence studies, and to a lesser extent, in research on domestic violence. Social gerontology is useful in that it emphasises the importance of age alongside other characteristics and contexts, however it has not been widely applied to gender-based violence and, for the most part, has neglected gender in its analyses. As with other theories, such as feminism, social gerontology provides a perspective rather than a single unified theory. Indeed, social gerontology has been heavily criticised over the last two decades for a lack of theoretical contributions to the field. Baars *et al*. (2006, p.1) argue that 'despite its explosive development over the last half-century, social gerontology has been characterised by an imbalance between the accumulation of data and the development of theory'.

Feminism has not been entirely absent from gerontology. As Netting (2011) points out, critical gerontology includes feminist contributions, but scholars such as Neysmith and Reitsma-Street (2009) have pointed out that ageing has not been central to feminist theory. Freixas *et al*. (2012) argue that 'historically, academic feminism has paid scant attention to ageism, to age relationships or to old age itself' (p.45). Feminist gerontologists are still few and far between, and often go unacknowledged by mainstream scholars and practitioners (Calasanti, 2004, p.1). However, the emerging feminist gerontology field can provide a framework for understanding and explaining sexual violence against older women (and men). Garner (2014) highlights the similarities between gerontology and feminist theories. Common goals include the development of social consciousness about inequities, utilisation of theories and methods that accurately depict life experiences, and promotion of change in conditions that negatively impact older people or women (p.6). Thus, by examining sexual violence against older people through a critical feminist-gerontology lens, both gender and age become central.

This feminist gerontology approach shares similarities with intersectionality, in that it is concerned not only with gender, but with other variables including age. Intersectionality was coined in the 1980s by black feminist writers bell hooks (1981) and later Crenshaw (1989) as a way of describing the multiple oppressions black women faced. Whereas feminism is primarily concerned with the importance of gender and the oppression faced in general by women, intersectionality stresses the importance of the interwoven nature of different categories such as race, class, and gender, and how they mutually strengthen or weaken each other (Crenshaw, 1990; Winker and Degele, 2011). Terms such as 'double disadvantage' and 'double jeopardy' have been used to describe the experiences of people who could potentially be subjected to multiple forms of discrimination. Intersectionality thus

provides a framework for understanding the interaction of multiple marginalisations to explain how power attaches to particular socially constructed categories and is exercised against others (Taefi, 2009, p.350). It builds on the radical feminist perspectives described earlier in this thesis, furthering our understanding by 'drawing out the diverse ways that oppression and discrimination intersect to disadvantage women' (Buchanan and Jamieson, 2016, p.224). Furthermore, as Buchanan and Jamieson point out, in relation to sexual violence the lens of intersectional feminism makes more visible women's experiences across diverse ages.

Intersectionality provides both a methodological and a theoretical approach that can capture the dynamic interrelationships between social divisions (Moore, 2009), traditionally gender, race, and class, (Bradley, 1996). Although intersectionality allows for the integration of other socially defined categories, such as age (Winker and Degele, 2011), research has largely ignored the overlap of ageism and sexism and has instead been mainly focused on ethnicity, race and sexism. However, it was useful to this particular study as it emphasises the need to consider gender alongside other variables, such as age and ethnicity, to develop understandings of sexual violence against older people. Whereas feminism has traditionally focused on gender, and social gerontology on age, intersectionality forces the researcher to consider both of these characteristics alongside others.

The guiding theoretical framework is therefore based on feminist principles, which acknowledge that sexual violence is extremely common in the lives of women and girls and runs along a continuum in terms of frequency and impacts (Kelly, 1988), whilst incorporating some elements of social gerontology and intersectional theories. Rhode (1990) points out that, although feminist research 'differs widely in other respects' (p.619), the theories they are underpinned by share three central commitments; political, substantive and methodological. On a political level, they seek to promote

equality between women and men. On a substantive level, feminist critical frameworks make gender a focus of analysis and finally, on a methodological level, these frameworks aspire to describe the world in ways that correspond to women's experience and that identify the fundamental social transformations necessary for full equality between the sexes (Rhode, 1990).

On a political level and substantive level, this study explored rape and sexual assault against older women as a phenomenon in its own right, independent of the elder abuse paradigm, which has to date been oblivious to gender, despite research demonstrating women are overwhelmingly the victims of all forms of interpersonal abuse. It thus contributes to the existing sexual violence literature which has excluded age, and the social gerontological literature which has excluded gender, bridging two disciplines which have traditionally remained distinct. A feminist gerontology perspective is suitable for researching violence against men and women. As Calasanti (2004) argues, feminist gerontology 'challenges mainstream scholarship for not naming men as men and thus enables us to theorise gender relations: the power relations that construct the interdependent categories man and woman' (s305). Moreover, this perspective 'sensitizes us to other power relations such as age relations and is appropriate for studying both female and male victims of sexual violence, even though women are the majority of victims' (s305). By examining age as well as gender and ethnicity, this research also draws from, and contributes to, the intersectionality literature.

The methodology of this research was committed to not only documenting the extent of sexual violence against older women in the UK, making visible a previously hidden and marginalised group, but also to hearing survivors' narratives through qualitative interviews, which facilitates the sharing of their subjective experiences. This is rooted in a constructivist grounded theory approach

(Charmaz, 2006), which is argued to uphold the goals and values of feminist research (Allen, 2011). The methodological framework of the research is outlined in Chapter 3.

1.4 Definitions and concepts

1.4.1 Defining sexual violence against older women

Although violence against women has always existed, it is only in the last twenty years or so that the international community has begun to highlight and systematically define the problem (FRA, 2014). Sexual violence is one form of violence against women and has been defined by the World Health Organisation (WHO) as:

> 'Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work.' (2012, p.2)

This broad definition encompasses a wide range of behaviours, from those normally viewed on the most serious end of the legal scale (for example, rape) to those often viewed on the less serious end (for example, indecent exposure or 'flashing'). Within the research domain, a variety of terms are used to describe behaviours considered to be sexually violent. In large national surveys on crime victimisation, sexual violence is often considered under the wider 'intimate' or 'interpersonal' violence and there are clear overlaps in the UK with definitions of domestic violence. The most recent definition of domestic violence was widened in 2013 to include those aged 16 and 17 years old. The current cross-government definition of domestic violence is:

> Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. (Home Office, 2013b)

Sexual offences committed against certain age groups are often termed differently. For example, where rape or sexual assault is perpetrated against a child, it is often referred to as 'child abuse', even where the behaviour clearly falls within the criminal definitions of sexual offences operating in England and Wales. Similarly, when rape or sexual abuse is perpetrated against those considered to be 'older' it is often defined as 'elder abuse'. Originally, the term 'elder abuse' was used to identify and label domestic violence experienced by older people in research emerging in the late 1980s (Mann *et al*., 2014; Bagshaw *et al*., 2009). The variety of definitions that exist have been argued to produce a 'definitional chaos' (Mysyuk, Westendorp and Lindenberg, 2013, p.50) for researchers, practitioners and policy makers. Generally, elder abuse definitions incorporate physical and non-physical abuse perpetrated by family members or those in relationships where there is an expectation of trust (WHO, 2002; 2010). Such definitions are thus limited in scope as they do not include instances of sexual violence perpetrated by acquaintances or strangers, or people with whom there is not an established expectation of trust. Furthermore, despite an increase in research and policy attention to preventing and responding to 'elder abuse', the focus tends to be on physical, emotional and financial forms of abuse. Sexual abuse is rarely given any substantial attention and in several surveys and studies it has been considered a subset of physical abuse (Schiamberg *et al*., 2011).

Several commentators have noted that the discourses around elder abuse, domestic violence and sexual violence have evolved separately and continue to be treated as distinct (McCreadie, 1996;

Whittaker, 1995; Penhale, 2003), which has consequences and implications for survivors who may receive inconsistent responses from practitioners, particularly those working in health or the criminal justice system, and may be confused about who to approach to make a disclosure or access support. In terms of practice, it has been described as an 'ideological gulf' between those working in domestic violence services and those in aged care (Scott *et al*., 2004, p.7). This creates a gap in knowledge and practice. For example, Harris (1996) points out that when violence against older women is viewed as elder abuse rather than domestic abuse, public services are largely health-based and such interventions may prioritise prescribing antidepressants or sedatives, recommending couples or family counselling or providing help for the abuser (Brandl and Horan 2002), which are the opposite responses to those as identified as best practice with domestic or sexual violence victims.

Research has found that women themselves will often have a wide variety of understanding and perceptions of what constitutes rape and sexual assault (Mann *et al*., 2014) and many will not situate their experiences within formal official or research definitions of these offences (Hamby and Koss, 2003). Therefore, although it may be clear in legislative and policy documents what constitutes rape or sexual assault by penetration, the social constructions and perceptions of these offences differ markedly and awareness of this must be made explicit in research around sexual violence.

In the UK, many forms of sexual violence have been given an official definition and criminalised under the Sexual Offences Act (2003). The two offences considered to be on the most serious end of the legal spectrum are 'Rape' and 'Sexual Assault by Penetration', which are contained in section 1 and 2 of SOA 2003, respectively. For rape, the definition states:

A person (A) commits an offence if—

(a) He intentionally penetrates the vagina, anus or mouth of another person (B) with his penis,

(b) B does not consent to the penetration, and

(c) A does not reasonably believe that B consents.

For sexual assault by penetration, the definition states:

A person (A) commits an offence if—

(a) He intentionally penetrates the vagina or anus of another person (B) with a part of his body or anything else,

(b) The penetration is sexual,

(c) B does not consent to the penetration, and

(d) A does not reasonably believe that B consents.

These definitions are the ones adopted in this study, which specifically explored the incidence, nature, characteristics and impacts of these two offences against people aged 60 or over at the time of the offence. The term 'rape' is used in this thesis in line with the legal definition to refer specifically to the sexual offence of rape, rather than to describe sexual violence more generally. When describing or referring to other forms of sexual violence, the specific offences or the broader term 'sexual violence' is used. Although other research and individuals themselves will have different perceptions, understandings, and definitions of what constitutes rape or sexual assault by penetration, this study explored statistical data and qualitative accounts of these two offences and therefore the operating criminal definition was used for consistency. However, the contexts in which these offences were committed was not restricted to specific relationships. Furthermore, no definition was imposed on the practitioners who were interviewed in Phase 2 or the survivors who

were interviewed in Phase 3 of the research, in acknowledgement that different people attach different labels and meanings to their experiences and using criminal definitions may not accurately reflect their experiences. Instead, 'sexual violence' was used when interviewing survivors and practitioners.

1.4.2 Defining 'older'

Defining 'older' and deciding who should be placed in the category of 'old' or 'elderly' is an area that has been rooted in debate for the last three decades. Wenger (2002) suggests that before any definition can be proposed, it is important to consider two questions: who are older people, and who are they older than? 'Old age' is defined in various public policies as anywhere between 50 and 70 in the UK. For example, Scotland use 50 as the starting point in their policy on planning for an ageing population in Scotland (Scottish Executive, 2007). The Crown Prosecution Service (CPS) policy for prosecuting crimes against older people defines this group as 60 and over. However, the 2010-2015 government policy on older people published by the Department for Work and Pensions uses 50 as the starting point in their policy. In Northern Ireland, the annual update of the ageing population in 2015 focused on the population aged 65 and older (Office of the First Minister and Deputy First Minister, 2015).

To further complicate matters, inter-departmental definitions are used within governments and other organisations. For example, Age UK, a charity providing support and advice for older people through a national helpline, webpage and local centres, generally market their services to those aged 50 and over. However, in a recent report on later life, they defined older as 65 and over (Age UK, 2014). In the existing sexual violence literature the term 'older women' has been applied in different

studies to variously mean women aged 50 and over, 55 and over, 60 and over and 65 and over (Mann *et al*., 2014). As Lea *et al*. (2011) have pointed out, the terms 'old', 'older' and 'elderly' are inconsistently applied with all of these terms being variously applied to people aged anything from 50 years and over by different researchers, policy makers and practitioners. However, in most of post-war Britain, old age (insofar as it is socially constructed) has been based around, and informed by, social policy and is often defined by an age of 65 and above, the traditional age for male eligibility for the state pension (Walker and Maltby, 1997). This lack of consistency makes it difficult to draw comparisons and conclusions across the existing literature.

The definition of 'older' for the purposes of this doctoral research was 60 years and over. There were two key justifications for this: first, people, in particular women, aged 60 and over have been ignored in the majority of sexual violence research, policy and practice, and are excluded from the national victimisation study, the Crime Survey for England and Wales, which collects data on domestic and sexual victimisation in the self-completion intimate violence module. Consequentially, we have no data nationally on the sexual victimisation of this age group. This is further compounded by the lack of available police data on the prevalence of sexual offence incidents involving people aged 60 and over. Second, although different government departments, organisations and researchers in England and Wales have adopted differing minimum age for defining 'older', the World Health Organisation (n.d.b) have suggested a lower starting age of 60 for older age.

1.4.3 Victim or survivor?

There has traditionally been much debate across academic and practitioner discourse about the appropriate terminology to describe an individual who has been raped. Traditionally, the term

'victim' was used, however this was criticised in the 1970s and 1980s as carrying victim-blaming connotations and depicted the individual as dependant and helpless (Walker, 1979; 1984). As Kelly and Radford (1990, p.40) point out, 'feminists have substituted the word 'survivor' for 'victim', in order to both challenge victim-blame and make visible women's and children's resistance and coping strategies'. The term 'survivor' is sometimes preferred as it is viewed as more empowering. However, there is a lack of agreement by women (and men) about the term they prefer to describe their experience. Moreover, the two terms are used inconsistently in practice and research, often reflecting the context. For example, the police and criminal justice system deal with 'victims' of crime, therefore they refer to individuals who are raped as victims, whereas sexual violence practitioners and those in health and social care are concerned with supporting people and tend to use the term 'survivor' instead. In this thesis, both 'victim' and 'survivor' are used interchangeably, as the research involved data from the police as well as sexual violence practitioners and victim-survivors themselves.

1.5 The ageing population and risk of violence

The world population is rapidly ageing. By 2030 over a billion people worldwide - one in every eight of the earth's inhabitants and almost double the current number - are forecast to be over 65. In the UK, 10.3 million people are aged 65 or over and this number is projected to increase to over 16 million in the next 20 years (Minocha *et al*., 2013). As Herring (2009) points out, these demographic changes will impact on society in profound ways; despite a growing number of healthy older people, their place in society is marginalised.

Ageing and old age are gendered. Indeed, it has been pointed out we are witnessing a feminisation of old age; women form 72 per cent of those aged 85 and over (Walker and Naegele, 2009). Women

have a higher life expectancy at birth than men, with an average of 82.6 years for women compared to 78.7 years for men. At the age of 65, women are still expected to live longer than men and there are more than double the number of women aged 90 and over in the UK than men (ONS, 2014). There are more elderly women living longer than their male contemporaries, which in turn increases the number of women who are widows and living alone in later life. 3.8 million women, aged 65 plus live alone. This is 36 per cent of all people aged 65 plus in Great Britain, 70 per cent of these are women. (ONS, 2011 in Age UK, 2014)

Older people are often isolated from society and in poverty, particularly older women: 1.8 million pensioners are in poverty and two-thirds of these are women (Age Concern 2008). Research indicates that more than 40 per cent of people over the age of 65 will enter a nursing home before they die (Murtaugh *et al.*, 1997). Furthermore, a significant number of older people, particularly women, are at risk of experiencing abuse in later life (Hodell *et al*., 2009). However, not all older people are vulnerable or socially isolated or lonely and in need of help: many older people, in fact, are active and engaged in volunteering or looking after younger relatives or even studying for degrees or short courses (Minocha *et al*., 2013). Concerns around making ageist assumptions about the perceived vulnerabilities, linked to stereotypes and attitudes that view ageing as a process of decay, decline and deterioration (Jones and Powell, 2006) have been highlighted and challenged in research and policy literature, but remain pervasive across society.

It is generally thought that the risk of experiencing violent crime decreases with age. It is a well-established and widely cited criminological fact that perpetrating crime and being a victim of crime decreases with age, often referred to as the age-crime curve/distribution. However, research from both elder abuse and domestic violence fields have revealed that the risk of experiencing violence,

particularly for women, does not cease in later life. Ongoing research by Ingala-Smith (2013; 2014) recording the number of fatal male violence attacks against women has found women aged 40 and over form the majority of those killed and the most frequent perpetrators are husbands, partners or other male family members including sons. This is supported by a developing pool of studies which have found between 15 per cent-26.5 per cent of women in midlife and older report intimate partner violence (IPV) (Weeks and LeBlanc, 2011; Scott *et al*., 2004; Women's Aid, 2007; Morgan Disney and Associates, 2000; Mouton, 2004). These figures are not dissimilar to the national statistics, which estimate around 25 per cent of younger women experience domestic violence and there have been suggestions that older women experience physical and verbal abuse at a similar rate, or even higher than, young women (Mouton, 2004).

Thus, research and official statistics from outside of the UK has identified that older people, in particular older women, are at risk of domestic and sexual violence and has demonstrated that sexual violence against older women is not as infrequent as it has been perceived to be (Cooper and King, 2006 in Lea *et al*., 2011). However, despite this and the impact of the ageing population leading to an increase in health, social care and gerontology research; policy and service provisions, the issue of sexual violence against older people has remained largely hidden.

1.6 'Real Rape' and Older Women

One of the possible explanations for the lack of attention into sexual violence against older women is the widespread acceptance of rape myths and stereotypes. The term 'real-rape' was introduced by Estrich (1987) to describe the dominant stereotype around what constitutes rape. Estrich argues this stereotype involves a white, young victim who is attacked at night by a stranger who is motivated by

sexual gratification. The 'real rape' stereotype is a central theme throughout this research and is discussed in relation to the findings in all three phases of the research.

Since the 1980s a plethora of research has emerged, which has challenged the accuracy of this stereotype. For example, in the United Kingdom, national data suggest that only 15 per cent of rapes involve a stranger (Office of National Statistics [ONS], 2015) and research has observed that women are most likely to be assaulted by a partner or acquaintance, often in social situations that involve alcohol (Kelly *et al*., 2005). Despite this, the 'real-rape' stereotype persists in society and is perpetuated by the media who tend to report cases of rape that are in keeping with this stereotype (Korn and Efrat, 2004; Franiuk *et al*., 2008; Marhia, 2008).

Many police campaigns continue to reflect (and possibly reinforce) the real-rape stereotype involving young women, strangers and acquaintances, alcohol and sexual desirability. The damaging effects of this dominant belief have been well documented: victims are aware they have to convince the police of the legitimacy of their experience (McMillan and Thomas, 2009) and cases that conform to the 'real-rape' stereotype are more likely to result in prosecution (Brown *et al*., 2007; Ellison and Munro, 2009). Moreover, it has also been suggested that perceptions of and beliefs about rape may also reflect, in part, the way researchers have depicted rape (Hockett *et al*., 2015) for example through vignettes used in studies. However, arguably, the extensive focus on certain populations in research studies and samples and the exclusion of other groups (e.g. older groups) also reinforces the notion that rape is a young persons' crime.

Furthermore, victims who experience rape that does not fit into the real-rape mould are often disbelieved or discredited and may be reluctant to report the rape to the police or other agencies.

Women's voluntary sector anti-rape campaigns and activism generally do not perpetuate the real-rape stereotype, but they do typically focus on young women. The notable exception here is the Zero Tolerance 'From 3 to 93-Women are Raped' poster in the 1990s, which showed an older woman, sat watching over a child (assumed to be her great/granddaughter) playing with toys on the floor.

Older rape victims do not fit the 'real-rape' stereotype of a young attractive woman who is attacked because of her sexual desirability. Society tends to view older people as asexual, largely based on ageist attitudes, which view old age as a process of decay, decline and deterioration (Jones and Powell, 2006). Sexuality in old age continues to be a taboo subject in society, and the existing academic literature has predominantly focused on sexual health and physiological issues in older age (Kleinplatz, 2008), giving the impression that sex in later life is either non-existent or associated with negative issues. As several researchers have noted, older people are routinely viewed as asexual and undesirable (Calasanti and Slevin, 2001; Gott and Hinchliff, 2003) despite research demonstrating that sexual activity continues into later life (Lindau *et al*., 2007; Beckman *et al*., 2008). Women, in particular, are depicted as either unsexy, 'frigid' or as 'cougars': a term used as a 'pejorative that reinforces age and gender stereotypes' (Montemurro and Siefken, 2014, p.35).

Furthermore, the real-rape stereotype posits that rape occurs late at night in public, a time when older people are less likely to be in public spaces. Thus, the lack of research and the common myths and stereotypes surrounding rape, and societal assumptions about age and ageist attitudes, may lead to disbelief or discrediting of the older person's complaint.

Generally, society does not identify older people as being at risk from sexual assault and thus family, friends and professionals may miss the signs (Lea *et al*., 2011, p.2304). Despite the feminist effort to

challenge these dominant myths, there has been very little research or activism challenging the myth around victim age. Whilst this lack of attention has been pointed out by a number of scholars (Whittaker, 1995; Aitken and Griffin, 1996; Jones and Powell, 2006), there remains a lack of feminist research exploring sexual violence against older women, which may further re-enforce the belief that rape is a young persons' problem.

1.7 Structure of thesis

This opening chapter has introduced the research, the primary aims, objectives and rationale for undertaking the thesis, the key concepts and definitions, the theoretical perspective underpinning it and has contextualised the invisibility of sexual violence against older people. The following chapter provides an overview of the existing research across the three related fields of inquiry: sexual violence, domestic violence against older women and elder abuse, focusing on the prevalence and nature of sexual violence against women aged 60 and over, the impacts and effects of sexual violence on older people and what is currently known about the perpetrators.

Chapter three discusses the methodology, outlining the framework which guided the studied and was heavily influenced by feminist principles towards conducting research. The chapter details the mixed-methods approach adopted to the research, and provides a research design outlining the three phases of empirical research, including the innovative use of Freedom of Information requests in Phase 1. The key methodological and ethical considerations are provide. Chapter three concludes with some reflections on conducting qualitative research with older rape survivors as a young, female researcher. Chapter four presents the findings from Phase 1 of the data collection, which was based on Freedom of Information (FOI) requests to police forces across the UK. It examines the extent of recorded rape and sexual assault by penetration offences between 1st January 2009 and 31st

December 2013 involving a victim aged 60 or over at the time of the offence. It also presents the findings in relation to the nature of these offences, specifically the victim and perpetrator demographics (age, relationship, ethnicity, whether the perpetrator was a known serial offender) and offences characteristics (the location of the sexual violence and whether it was linked to another crime). These findings are discussed in light of the existing sexual violence literature. Chapter five presents the findings from Phase 2 of the empirical research which involved qualitative interviews (n=23) with practitioners working in domestic and/or sexual violence organisations. The focus of these interviews was on exploring the impacts of sexual violence on older people, the challenges or barriers they face in accessing services or reporting to the police, the support needs of older survivors and the extent to which services feel able to meet these, and the gaps in service provision. Chapter six presents the findings from Phase 3 of the empirical data collection, based on three case studies of women who have been raped since the age of 60, which explored the impacts of sexual violence, their support needs, experiences of accessing support and of the criminal justice system, and gaps in available support for older survivors. The final chapter draws together these findings and presents them in relation to the six research objectives and outlines the priorities for future research, and the key implications for practitioners and policy makers. This chapter concludes by considering the key contributions to knowledge emerging from this thesis.

Chapter 2: Rape and sexual violence

2.1 Introduction

There are four key areas of academic literature that were relevant to this study. The first is the literature on sexual violence, specifically rape and sexual assault, some of which has already been addressed in the introduction section of this thesis (Chapter 1); the second is the literature on elder abuse; the third is a relatively new area of inquiry examining domestic violence against older women; and the fourth is the limited existing literature on sexual violence against older women and, to a lesser extent, older men. This chapter situates the existing knowledge around sexual violence against older women within the broader literature in these three areas. Feminist theories have made significant contributions to the violence against women fields and are of pertinent importance to this doctoral research, whilst social gerontology has made contributions to the research on elder abuse. Their contributions are outlined and the gaps in knowledge with older survivors are highlighted.

2.2 Extent and nature of sexual violence against older women

2.2.1 Extent of sexual violence against older people

The World Health Organisation (2013) estimates 35 per cent of women will experience at least one incident of sexual violence in their lifetime. In the UK, the two main sources of data on prevalence are the CSEW and police recorded data, described in Chapter 1.2. There have been no specific sexual violence prevalence studies in the UK. Furthermore, unlike some other countries in Europe and elsewhere, England and Wales (nor the rest of the UK) do not have a specific violence against women survey. A number of studies were conducted in the 1990s in Canada (Kelly *et al*., 2005) and Australia (Easteal, 1998). More recently, an EU-wide survey conducted by the European Union Agency for

Fundamental Rights (FRA, 2014) is the first of its kind on violence against women across the 28 member states of the EU and was based on interviews with 42,000 women who were asked about their experience of physical, sexual, and psychological violence. The survey also included questions on stalking, sexual harassment, and the role of technology. The authors estimated that 3.7 million women in the EU experienced sexual violence in the course of the previous twelve months before the survey interviews. The highest prevalence was in the youngest age group of women aged 18-29. In total, 6 per cent of women aged 60 and over experienced partner and non-partner violence in the previous twelve months. More specific data on forms of violence, including sexual violence, is not provided.

There are a number of limitations with the existing data in terms of our knowledge about sexual violence in later life. Whilst some of the European and international surveys have not always imposed an age cap, such surveys do not include in their sample respondents who live in nursing or care homes or hospitals, or those deemed not able to consent because of physical or mental incapacity affecting the ability to understand, and consent to, taking part in the survey. Furthermore, as the existing violence against women surveys have found young women to be the most at risk, the focus of the findings has mainly centred on this group, with little available information specifically about older groups. Finally, the existing surveys have often grouped categories of violence together, such as physical and sexual violence, making it difficult to get accurate estimations of the prevalence of specific forms of violence.

However, some data on the extent of sexual violence against older women (and men) can be drawn from other sources, falling into three (currently distinct) fields of research: elder abuse; domestic violence against older women; and sexual violence against older women. However, it is not possible

to gain accurate estimates of prevalence from the existing data, as the studies do not compare the same things. The ranging definitions, samples, methodological approaches and sources of data mean that most of the published literature is estimating different types of prevalence or frequency of incidents in subpopulations which do not provide an overall picture of extent in later life. Despite this limitation, the data is helpful in providing some idea of what is currently known about the extent of sexual violence against older people in different contexts.

In terms of elder abuse, some relevant data is available from official safeguarding sources. Official data from Adult Safeguarding Services in the UK provide figures on the number of referrals to local councils for suspected sexual violence/abuse. In 2012-2013 there were 109,000 safeguarding referrals made to Councils with Adult Social Services Responsibilities (CASSRs) in the UK. Overall, 61 per cent of referrals were for women and 62 per cent were for adults aged 65 or over. Around 1,890 of referrals were for sexual abuse involving an adult aged 65 or over (HSCIC, 2014). In a USA 2004 survey of Adult Protective Services Agencies, seventeen states reported 1,348 investigated cases of sexual abuse of vulnerable adults aged 60 and over and indicated that one per cent of substantiated (cases believed to be founded or true based on the process of investigation) elder mistreatment cases involved sexual abuse (Baker *et al*., 2008). More recently, Roberto and Teaster (2005) analysed a sample of 125 sexually abused women, obtained through Adult Protective Services, and reported that women older than 59 years represented the majority (63 per cent) of cases.

The area of elder abuse has attracted significant research attention over the last two decades, though this has mainly emerged from medicine, health and social care disciplines. As Ramsey-Klawsnik *et al*. (2007) points out, the least perceived, acknowledged, detected, and reported type of elder victimisation is sexual abuse. Internationally, many elder abuse surveys have traditionally excluded

sexual violence from their studies, and some continue to do so. Early prevalence studies between 1986 and 1994 across Boston (USA), Canada, Great Britain and Amsterdam focused on a narrow range of behaviours and all neglected sexual violence. Furthermore, the age ranges differed across surveys with some adopting lower limits of 60 (Great Britain) and others with upper limits of 84 (Amsterdam) (Ogg and Bennett, 1992). A more recent, smaller national study based in Israel (Eisikovits, Winterstein and Lowenstein, 2004) utilised survey interviews with 1,042 people aged 65 and over and examined seven forms of abuse (physical, emotional, verbal, limitation of freedom, financial abuse, exploitation and sexual abuse). Elder abuse perpetrators were categorised as spouse, family members or other caregivers and types of abuse were: physical and sexual abuse; verbal abuse; limitation of freedom; financial exploitation; and neglect. The findings indicated that 18.4 per cent of respondents were exposed to at least one form of abuse during the 12 months preceding the study. Physical and sexual abuse were fairly infrequently reported, with about two per cent of respondents reporting these types of abuse. One limitation with this study is that physical and sexual abuse was grouped together and statistics are not provided for each type of abuse separately. A recent large scale study from the USA examined quantitative survey data from 24,343 older adults aged 60 and over from the 2005 'Behavioral Risk Factor Surveillance System' and reported 0.7 per cent of people had experienced sexual violence in the previous 12 months (Cannell *et al*., 2014). The vast majority were female.

In 2004 a national study on the abuse and neglect of older people was commissioned by the Department of Health and Comic Relief and conducted by O'Keeffe *et al*. (2007). This study included sexual abuse and defined it as 'direct or indirect involvement in sexual activity without consent' (O'Keeffe *et al*., 2007, p.14). This information was collected through interviews in self-completion format (laptop or paper based) with people aged 66 or over living in private households, including sheltered accommodation. A total sample of 1,784 individuals from England, Scotland and Northern

Ireland took part in the survey with a further 327 in Wales. The research included questions on a range of behaviours including being forced to watch pornography against their will, being talked to or touched in a sexual way or sexual intercourse against their will. Furthermore, the study also asked about attempts to carry out these behaviours. Respondents were asked about whether they had experienced any of these behaviours over the past year by a family member, close friend or care worker. Thus, the survey was limited in that it did not collect data on experiences by strangers or acquaintances. Overall, the study found a prevalence rate of 2.6 per cent of mistreatment involving a family member, close friend or care working during the past year, equating to about 227,000 people aged 66 and over in the UK who were neglected or abused in the past year. Women were more likely to say they had experienced mistreatment (3.8 per cent). In terms of sexual abuse, the prevalence rate across the sample was 0.2 per cent, equivalent to 13,100 people aged 66 and over in the UK. Of particular interest was the age breakdown of data, which revealed that no one aged 85 and over reported 'interpersonal abuse' over the previous year (incorporating psychological, physical and sexual abuse).

More recently, a study has been conducted in Ireland (Naughton *et al*., 2010). Like the previous elder abuse studies, the definition of elder abuse was restricted to perpetrators in a position of trust, namely family, in-laws, close friends and care workers. Types of abuse were categorised as any episode of financial, physical or sexual, psychological abuse or neglect occurring in the previous 12 months. The final sample consisted of 2,021 people aged 65 and over who were living in the community, including sheltered accommodation. Importantly, exclusion criteria included those deemed not to have sufficient cognitive ability to complete the interview, though cognitive status was not formally assessed and was based on a person's ability to answer questions consistently and maintain attention for the duration of the interview. They reported a total of 25 interviews being

terminated due to deemed cognitive impairment, described as participants appearing confused or providing inconsistent answers to questions. Data was collected through face-to-face interviews. A prevalence figure of 2.2 per cent was reported, estimated equivalent of 10,201 in the general population of people aged 65 and older, with women reporting higher levels across all types of abuse. Sexual abuse prevalence was the lowest reported at 0.05 per cent, extrapolated to an estimated 234 people in the general population of older people. A recent European study (Soares *et al*., 2010) examining types of elder abuse experienced by people aged 60-84 across seven countries (Sweden, Germany, Lithuania, Greece, Portugal, Spain and Italy) (n= 4, 467) reported a prevalence rate of 0.7 per cent sexual violence experienced in the previous 12 months. The vast majority of victims of sexual violence were women.

There are a number of limitations with the existing studies, including the lack of consistency in the definitions, and types of abuse, included in the research. Moreover, similar to other more general victimisation surveys, those living in care homes or hospitals are generally excluded. For example, the CSEW does not cover the population living in group residences or other institutions on the grounds that this population comprises a small proportion and it would not be feasible to cover communal establishment residents in a statistically reliable manner without incurring very substantial additional costs (Pickering *et al*., 2008).

A recent study by Purdon *et al*. (2007) was conducted to consider the feasibility of a study to measure the prevalence of abuse of older people in care homes. The feasibility study (Purdon *et al*., 2007) concluded that a survey of mistreatment of older people living in residential and nursing care homes would be possible, but challenging. They made a range of suggestions around potential survey design and implementation. However, the Department for Health decided that definitional and conceptual

issues around abuse of older people meant there was a need to explicitly establish and agree definitions of key concepts and the differences between them, before empirical work is undertaken in care homes (Tender document, 2008). As a result, a study by Dixon *et al*. (2009) was conducted to explore and clarify definitional issues in advance of a prevalence survey of abuse, neglect and loss of dignity in residential and nursing care homes; making recommendations for the way in which key concepts are defined and for how operational definitions and measures are arrived at. To date, there has been no elder abuse study conducted in care homes in England and Wales. However, whilst standard surveys and national studies on sexual victimisation have excluded those living in care homes or similar institutions, a small number of studies have emerged which specifically consider abuse in the context of care homes or other residential care settings (e.g. Post *et al*., 2010; Bužgová and Ivanová, 2009; Jogerst *et al*., 2006; Teaster and Roberto, 2003). Most of these studies emerge from outside of the UK and are limited in their methodology, however they do provide a starting point. An early study conducted in respite care environments in England observed few complaints about abuse from patients, however anonymous admissions of abuse were made from 45 per cent of their carers (Homer and Gilleard, 1990). Finally, most[1] elder abuse studies are limited to family, close friends or care-providers (sometimes referred to as those in positions of trust) and thus do not capture the prevalence of sexual violence perpetrated by strangers or acquaintances, or by peers or care providers within institutions or care homes. Research specifically examining sexual violence in care homes is discussed in this chapter at 2.1.4.

A relatively new area of inquiry is domestic violence (hereafter DV) against older women. Whilst sexual violence is generally included in definitions of domestic violence, specific types of abuse are often not considered separately and thus sexual violence is often considered a subset of physical

[1] O'Keeffe *et al.* (2007) did include neighbours and acquaintances

violence. As with sexual violence, the intimate violence module capturing domestic violence victimisation in England and Wales has a cap of 59 so there is no national data. Consequently, several researchers have sought to examine the extent of victimisations through specific studies with estimates ranging between 15 per cent-26.5 per cent of women in midlife and older experiencing sexual violence (Weeks and LeBlanc, 2011; Scott *et al*., 2004; Women's Aid, 2007; Morgan Disney and Associates, 2000; Mouton, 2004; Fisher *et al*., 2010; Bonomi *et al*., 2007). Recently, research by Stöckl *et al*. (2012) examined the prevalence of intimate partner violence (including physical and sexual) in older (50-65) and elderly women (66-86) in Germany, based on the data from the national study. They found that 33 per cent of older and elderly respondents reported lifetime prevalence of physical and sexual partner abuse; 23 per cent among women aged 50 to 65 and 10 per cent among women aged 66 to 86. When restricting the sample to those currently in a relationship, 14 per cent of 50 to 65 year olds and five per cent of women aged 66 to 86 reported physical or sexual violence by their current partner. Four per cent of the 50 to 65 year olds reported only sexual violence, with none in the older group. Such studies are useful in that they capture a subpopulation who are commonly excluded from other studies, particularly surveys, because they are not in domestic dwellings or are older than the inclusion criteria allows for (for example, the CSEW). If these estimates are correct, women aged over 50 are at a similar risk as those aged between 16 and 30.

A European-wide study examining the prevalence of violence against older women in intimate relationships across six countries found that 23 per cent of cases dealt with by relevant organisations involved sexual abuse (Nägele *et al*., 2010). From the DAPHNE III (AVOW Project) initiative in the European Union, overall sexual abuse prevalence rates for older women aged 60 years and above reported by countries that participated in the prevalence study (Austria, Belgium, Finland, Lithuania, and Portugal) was 3.1 per cent (Luoma *et al*., 2011).

However, similar to elder abuse studies, the definitions of domestic violence are usually restricted to physical, emotional, sexual and financial abuse perpetrated in the context of an intimate, or familial, relationship. Therefore, these studies do not include violence perpetrated by strangers, acquaintances, friends or neighbours. Moreover, the majority of these studies have focused on physical or emotional forms of violence, with less attention paid to sexual violence. Because of the range of violence covered by the definitions, it is difficult to separate sexual violence from other forms, which makes it hard to gain estimates on sexual violence victimisation.

In response to the lack of available data on the extent of sexual violence against older women, a small number of specific studies have emerged over the last decade with the aim of estimating incidence. In England, the only study to look specifically at prevalence was conducted by Ball and Fowler (2008) who focused on the incidence and characteristics of sexual violence against older women. The study was based on all recorded offences within a semi-rural English county with a population of approximately 800,000. They analysed all recorded sexual offences over a five-year period (n=1,061) and found 3.1 per cent involved victims aged 55 years or more. In Ireland, research by Scriver *et al*. (2013) involving an analysis of rape crisis data reported a total of eight per cent of the 2,036 survivors accessing services in 2011 were aged 55 or over. The study separated the older survivors into those accessing services for childhood sexual abuse and those who had experienced the abuse as an adult. The majority were seeking help and support for childhood sexual abuse (54 per cent) with around a third accessing for adult sexual violence only (33 per cent).

Internationally, a small number of studies attempting to measure the incidence or extent of sexual violence against older women have been conducted, mainly in the USA. In 1971 in a study of 646

rapes in Philadelphia, Amir reported that 3.6 per cent were over the age of 50 (Lea *et al*., 2011). Also in 1971, MacDonald analysed 200 consecutive case in Denver and found that seven per cent of victims were aged over 50. Eight years later, Davis and Brody (1979) reported a rate of somewhere between 1.4 and 15 per 1,000 rapes involved older women in the United States. Ramin *et al*. (1992) reported that approximately two per cent of victims of rape in Dallas County in 1991 were women aged 50 years or older.

2.2.2 Nature and characteristics of victimisation

In addition to prevalence statistics, the CSEW also collects data on the nature of crimes, including rape and sexual assault, within the 'intimate violence' self-completion module. The information collected includes the age of victims and offenders, relationships between victim and offender, location of assaults and lifestyle factors of victims. The latest statistics report that single females (including those who were separated) were more at risk than females with different relationship statuses. Furthermore, female full-time students and those unemployed or with a household income of less than £10,000 were also more at risk. In terms of victims' household circumstances, prevalence rates were higher among females living in a flat or maisonette, those living in a city and those in rented accommodation (either social or private rented) (ONS, 2013).

In terms of victim-offender relationships, three categories of rape have been identified in the existing literature: stranger, acquaintance and rape or sexual assault by someone the victim knows (typically a partner, ex-partner or other family member or friend). Stranger rape or sexual assault occurs where the victim has no prior knowledge of the perpetrator. Where the victim knew the perpetrator even for a brief period of time, this is then categorised as acquaintance rape/sexual assault (Harris and

Grace, 1999). The most recent statistics by the ONS (2013) reveal that, for victims of the most serious offence types (including rape and sexual assault) the most commonly reported victim-offender relationship was partner (including ex-partner) (56 per cent). For female victims of other sexual offences, including indecent exposure and voyeurism, the offender was most likely to be a stranger (52 per cent). In around a third of both the most serious and other sexual offences, the offender was somebody known to the victim (other than a partner or family member). This is supported by other research including an analysis of reported rapes in 2003/04 in England and Wales which found 86 per cent of rapes were perpetrated by a partner, ex-partner or someone else known to the victim (Feist *et al.*, 2007). It is widely accepted that the majority of rapes are not committed by strangers, but rather by acquaintances and trusted persons.

Across the sexual violence, elder abuse and domestic violence research a number of findings in relation to older victim are consistent with the national data on rape. The overwhelming majority of older victims of sexual violence are female (Soares *et al*., 2010; Iborra, 2008; O'Keeffe *et al*., 2007; Naughton *et al*., 2010; Ball and Fowler, 2008; Burgess, Ramsey-Klawsnik, and Gregorian, 2008; Teaster and Roberto, 2003). The vast majority of perpetrators are male, and research has found they are usually known to the victim. For example, O'Keeffe *et al*. (2007) found 51 per cent of overall mistreatment in the past year involved a partner/spouse, 49 per cent another family member, 13 per cent a care worker and five per cent a close friend (respondents could mention more than one person). For interpersonal abuse specifically (i.e. physical, psychological and sexual abuse combined) 80 per cent of perpetrators were men and 20 per cent were women. A study by Acierno *et al*. (2010) on elder mistreatment found the majority of physical abuse perpetrators were partners or spouses. Furthermore, a recent large-scale study in Europe, the DAPHNE III research initiative found the most prevalent category of abuser for physical and sex abuse was the spouse/partner (50.7 per cent and

55.4 per cent, respectively) (Luoma *et al.,* 2011. A slightly more recent study by Soares *et al*. (2010) examining different forms of abuse among elderly people across seven European countries (with a sample of 4,467) found the majority of perpetrators of sexual violence were friends, acquaintances or neighbours (30.3 per cent).

However, some research has found older women are more likely to be raped by a stranger than younger women. Early studies such as Groth (1978) reported the majority of his sample of 170 men who committed sexual offences against an older woman did not know the victim prior to the attack. A similar study by Davis and Brody (1979) in the US found that in 78 sexual assault cases in Nashville involving women aged over 50, the majority (68 per cent) were assaulted by a stranger and just under three quarters of the attacks occurred in their own home (73 per cent). More recent research supports these earlier findings. The study of Muram *et al*. (1992), in the USA, compared sexual assaults of 53 women aged 55 or over with 53 sexual assaults of women aged between 18 and 45. Significant differences were observed in the location of the assault and relationship between perpetrator and victim. They report that 72 per cent of the assaults against older victims occurred in the victim's home compared to just 19 per cent of younger victims. Furthermore, 79 per cent of older victims were assaulted by strangers compared to just 57 per cent of younger victims. Jeary (2005) analysed 52 cases of rape or sexual assault against women aged 60 or older drawn from national prison and probation databases in the UK and reported that in two thirds of the cases the attack took place in the victim's home and in only a few cases was the victim believed to be known to the offender. The remaining third of sexual assault and killing and rape/attempted rape offences involved perpetrators aged 31 and over and the majority took place in the victim's home or residential care home by someone known to her; either a relative, acquaintance or care worker. Similarly, Burgess *et al*. (2007) found the majority of assaults occurred in the victim's home (70.1 per cent) with

22.4 per cent in nursing homes and 6.6 per cent in other locations. In 61 per cent the victim did not know the offender although, on interview, many offenders said they knew the victim from the neighbourhood and knew the victim's daily routine, which Safarik, Jarvis and Nussbaum (2002) describe as a 'relative stranger'.

However, other research has found that sexual offenders of older women are normally known to the victim and are typically partners or husbands. In the USA, Ramsey-Klawsnik (1991), reported that, out of 28 cases of suspected elder sexual abuse occurring in the community (i.e. not in institutional settings like care homes) all the victims were female and most were sexually assaulted by their caregivers, with the largest category of perpetrators being husbands or adult sons. Only two in the case sample were sexually abused by unrelated caregivers. Furthermore, research drawn from data within institutions, such as care homes, shows that perpetrators are more likely to be peers of a similar age rather than staff (Burgess *et al.*, 2000; Roberto and Teaster, 2005). It is likely that these differences are in part related to the varied definitions, methodological approaches and nature of the samples in these studies.

In terms of the location of the rape or sexual assault, there is no available data from the Home Office. However, other research has examined the location of sexual offences. For example, Kelly *et al*. (2005) examined data at a Sexual Assault Referral Centre (SARC) between 1987 and 2002 and found that the most common location in which rape took place was a public place (32 per cent) followed by the victim's home (24 per cent) and the perpetrator's home (19 per cent). They reported minimal variation of locations of assault over time since 1987. Re-analysis of two data sets by Lovett and Horvath (2009), one from SARCs and one from police reports, showed that most rapes occur in either the social area or private space (most commonly the homes of victim-survivors or offenders).

The research examining sexual violence against older women reports similar findings. The vast majority of rapes and sexual assaults occur in the victim's home (Ball and Fowler, 2008; Lea *et al*., 2011; Burgess *et al*., 2007; Jeary, 2005; Pinto *et al*., 2014). Unsurprisingly, the age of the victim, living arrangement and location of the rape or sexual assault have been shown to be related. The 2009 study by Baker *et al*., explored the living arrangements of 198 women aged 50 and older drawn from an urban sexual assault centre in Washington. Of the 198 women, 58 lived in institutional settings, 70 lived at home or in domestic settings, 21 were homeless and 49 'unknown'. Differences in the age groups (50-79; 80-89; 90 and over) by living arrangements were statistically significant. In institutional settings, women aged 80 and older (43 per cent) and 50-59 (31 per cent) accounted for most of the victims. Across other living arrangement categories, the majority of victims were 50-59 years of age. A total 75 per cent of women, across settings, knew the suspected offender. However, of these women, approximately two thirds had known the suspected offender less than 24 hours. Statistical differences were also observed in the relationship of suspected offender to victim, with service providers accounting for 67 per cent of suspected offender in institutional settings and 47 per cent in cases in which the living arrangement was unknown. Acquaintances or friends accounted for almost half of suspected offender for women in domestic and homeless settings. For women in institutional settings, the suspected offender was another resident in at least five cases. Finally, in the study by Teaster *et al*. (2000), which concerned the sexual abuse of 42 older adults in both domestic and institutional settings and which relied on data from Adult Protection Service records, the majority of victims lived in nursing homes and the most frequent perpetrator was a facility resident (not care giver). The second most frequent perpetrator in the study was facility staff.

2.2.3 Risk factors for sexual violence in later life

Risk factors for violence and abuse of older women are difficult to identify from the existing literature because of the variety of definitions and methodologies used across the different studies, resulting in conflicting findings. Risk factors observed also depend on the particular framework the research is situated in – for example, older age is identified as a risk factor for neglect, abuse and violence if care needs and perceived or actual vulnerability are the focus of the studies (i.e. the elder abuse/social gerontology frameworks) but the opposite is found in domestic violence framework. In domestic violence and intimate homicide studies (Ingala Smith, 2013; 2014) older women up to age 65 are found to be at a greater risk of abuse and violence by intimate partners than elderly women aged 75 years and older. Additionally, a review of the existing literature by the UN (2013) found the forms of abuse differ, 'with more physical violence reported against older women at the younger end of the old age spectrum, and more psychological abuse reported at the older end of the old-age spectrum' (p.24)

From the existing research it would seem age and gender are two risk factors for abuse in older age. Luoma *et al*. (2011) reported a number of risk factors identified and others eliminated in the DAPHNE III AVOW study. They found that women in the 60-69 age group who were married, not fully retired, and reported poor physical and mental health had significantly higher prevalence rates of abuse than women in the 70-79 age group and 80 and over age group who were not married (widowed, separated or single) and reported good mental health. Furthermore, women who had retired had a higher probability of abuse compared to women who were still working. Similarly, Del Bove *et al*. (2005) and Brozowski and Hall (2010) found being single, female, widowed or divorced was associated with a higher risk of experiencing sexual violence. Living alone has been reported as

increasing risk of victimisation (Soares *et al*., 2010). Furthermore, social isolation and lack of social support and engagement with services (for example healthcare and social services) have been identified as risk factors for women in all commonly-used research frameworks (UN, 2013). Research by Simmelink (1996) reported that women over the age of 55 are a vulnerable group because of declining health and strength, financial limitations, housing conditions, limited sensory capacity, change in mental faculties, dependence on caregivers, and increased burdens on family members (p.619).

Poor physical and/or mental health has also been associated with a higher risk of victimisation (Baker *et al*., 2009; Brozowski and Hall, 2010; Burgess and Phillips, 2006; Del Bove *et al*., 2005; Flueckiger, 2008; Luoma *et al*., 2011). In their study of 119 alleged sexual abuse cases involving elder individuals residing in care facilities, Ramsey-Klawsnik *et al*. (2008) found victims suffered from a range of physical and psychological conditions. These included dementia (64 per cent), heart disease (45 per cent), diabetes (16 per cent) and Parkinson's disease (eight per cent). They found many victims were dependent on others, with 48 per cent requiring assistance in all activities of daily living. In a recent small study examining 14 cases of sexual violence involving an older victim in Portugal (Pinto *et al*., 2014, p.194) almost 58 per cent of the cases evidenced relevant previous pathological history; four had a physical disability (sphincter incontinence in case four, left hemiparesis in cases eight and nine, and severe hypoacusis in case 14), and two had a mental/cognitive disability (mental retardation and Alzheimer's disease in cases one and 12, respectively). Two of the individuals were completely unable to communicate (either through words or gestures) due to their impairments. Similarly, a review of sexual victimisation in the elder abuse literature found cognitive impairment was a risk factor, particularly dementia, or other conditions resulting in reduced or impaired orientation (Rosen *et al.*, 2010).

2.2.4 Sexual violence in care homes

As highlighted earlier in this chapter, one of the limitations of the findings in the existing studies is that the majority have either excluded sexual violence occurring in care homes or have found no cases from their data source where the sexual violence occurred in a care home (e.g. Ball and Fowler, 2008). Little is therefore known about sexual violence that occurs in care homes. However, a small number of studies have specifically examined this. Burgess *et al*. (2000) analysed 18 offenders who carried out their sexual assaults in care facilities. In 15 of the cases, offenders were employees, whilst three were residents. The study observed that all were low in social competence and targeted victim residents who were incapacitated. Ten of their victims were assaulted multiple times, and one perpetrator assaulted two residents. In terms of criminal justice, eleven employees were arrested, and five were convicted.

Teaster and Roberto (2003) conducted a study which analysed 50 substantiated cases of sexual abuse of older women residing in nursing homes. They found women aged 80 and over were more likely than those aged 70-79 to be abused. All of the offenders were male and the vast majority were nursing home residents (90 per cent) and were aged over 70. Other research suggests service providers, for example care staff, form the majority of perpetrators (Sobsey and Doe, 1991) although other service users also make up a significant proportion of perpetrators (Brown and Turk, 1992). Another study conducted by Teaster *et al*. (2007) examining sexual violence against older men in nursing homes found the most common offence was fondling. Most of the victims were aged 80 and over and most perpetrators were male and facility staff.

Ramsey-Klawsnik *et al*. (2008) conducted the first national study of sexual abuse of vulnerable adults residing in care facilities in the USA. The study drew on sexual abuse reports, investigations and case outcomes involving vulnerable adults ages 18 and older. The research examined a total of 429 cases of alleged sexual abuse that were investigated in five states during a six-month period. Of the alleged victims, 124 were aged 60 and older. Of these alleged victims, the ages ranged from 60 to 101, with an average age of 79 and the majority (n=96) were female.

In respect of alleged perpetrators, 43 per cent (n=51) were employees of the involved facilities whilst 41 per cent were residents of the facilities in which the abuse was alleged to have taken place. A total of five alleged perpetrators were family members of the elders, comprising three sons, one sibling and one parent. Forty-six of the alleged care staff perpetrators were ultimately accused, of which 28 were men, 17 were women (no information on the gender of one) and ranged in age between 19 and 65, with an average age of 37. The 48 accused residents ranged in age from 21 to 96 with an average age of 69. The majority were male (n = 46, 96 per cent). In total six were diagnosed with substance abuse, four had criminal histories, and two had been previously accused of committing sexual assault. The majority (73 per cent) of the elder sexual abuse cases occurred in nursing homes with the second most common location assisted living facilities (10 per cent). Other involved locations included residential care facilities (seven cases), community-based residential programmes (five), rehabilitation centres (four), state mental hospitals and ICFMR (three each), and adult family homes (two) (Ramsey-Klawsnik *et al*., 2008).

Regarding the action taken following the reports of abuse, data were available regarding 44 of the facility residents who were alleged sexual perpetrators. The majority (73 per cent) were transferred to another facility. In terms of the alleged care staff abusers, data were available for 37. Most of

them (n=32, 87 per cent) were placed on leave following the abuse allegations. In addition, nine (24 per cent) had their employment terminated and 11 (30 per cent) were reassigned to work in another location. Ultimately, six (16 per cent) staff members had their names submitted to a central registry of abusers.

The police were notified in all alleged cases, however none of the 32 confirmed sexual perpetrators were ultimately arrested. Only one of the alleged 119 elder sexual offenders faced arrest. This individual was a male care staff member working in a community mental health facility. He was alleged to have perpetrated emotional and sexual abuse. The worker was accused of engaging in harmful genital practices and anally raping the 65-year-old man with an object. In interview, the perpetrator admitted physical abuse and bruising the victim's genitals, however the case was substantiated only for physical and emotional abuse.

Ramsey-Klawsnik *et al*. (2008) argue this is a disturbing finding. Despite state authorities substantiating 33 cases of sexual assault of vulnerable elders residing in care facilities, none of the identified and confirmed 32 perpetrators were arrested. They highlight this amounts to compelling evidence of the need for greatly enhanced criminal justice involvement in facility abuse matters and the results strongly support the need for 'collaboration between those who conduct civil abuse investigations and law enforcement officers' (p.373).

2.2.5 Sexual homicides

The sexual homicide literate also contributes to the current knowledge concerning sexual violence against older women. Sexual homicides are heavily studied but poorly defined (Chan and Heide,

2009). Although rare, the seriousness of this violent crime attracts a great deal of attention from both the media and scientific community (Kerr, Beech and Murphy, 2013) with published articles now in excess of 50 across academic scientific journals (Chan and Heide, 2009). There is no universally accepted definition of the term 'sexual homicide', however in most cases it refers to the killing of another human which involves a sexual element, either before, during or after the killing (Porter *et al*., 2003) and thus it usually encapsulates two individual crimes: murder and rape or sexual assault. The lack of a unified definition makes it difficult to draw comparisons between the literature. A number of different terms have been used, such as 'lust murder', or 'sexual murder' which, despite often being used interchangeably, do not necessarily mean the same thing (Kerr, Beech and Murphy, 2013).

In line with other sexual offences, sexual homicides are overwhelmingly committed by men against women. As with the general sexual violence literature, the focus of the majority of research in this area has been on cases involving young victims. It is generally accepted that sexual homicides involving elderly victims are rare (Safarik, Jarvis and Nussbaum, 2002) however, this might be, in part, down to practitioners having less awareness of the occurrence of sexual homicides among the elderly.

The most recent research was conducted by Safarik, Jarvis and Nussbaum (2002). They examined data available from Supplementary Homicide Reports (SHR) collected by the FBI between 1976 and 1999. A total of 604 cases were identified during that period. Information on the crime scene details, nature and extent of victim injuries and similar case attributes were gained from the National Centre for the Analysis of Violent Crime (NCAVC). Analysis of the cases using the two sources above established offenders were typically white men with an average age of 27 (compared to a mean age

of 77 for victims). In most cases the victim and perpetrator were known to each other. In 69 per cent of cases the offender 'took items' from the victim.

In terms of the offender backgrounds, 90 per cent had criminal records with the most common (59 per cent) offence being burglary; only 21 per cent had sex offences in their criminal histories. Nearly 70 per cent were unemployed and the majority (93 per cent) had 12 years or fewer of formal education.

Offenders in these cases had sexually assaulted the victims vaginally (65 per cent) and anally (24 per cent), although black offenders had a slightly higher rate of both vaginal and anal assault than white offenders. Overall, foreign objects were used to assault the victim in 22 per cent of cases, and more than half of these were perpetrated by an offender who was younger than 24 years of age. In 63 per cent of cases the method of killing the victim was strangulation followed by blunt force trauma (38 per cent). Death by a firearm was relatively rare (1one per cent).

The most recent research in the UK comes from the large scale Murder Study conducted by Dobash and Dobash (2015) which looked at over 800 murder cases. Within their analysis they found a number of cases which involved an elderly victim and had a sexual element. In total, 76 cases involved an elderly victim and, within that, 21 cases involved an older woman and a sexual element. The majority of these were committed by a stranger. There were strong associations with alcohol and sexual homicides, with 70 per cent of offenders having ingested alcohol and 55 per cent being drunk at the time of the offence.

The average age of the male perpetrator was 30, whilst the average age of the woman was 75. However, in the cases involving a victim aged 80 or over (13) sexually motivated murders accounted for nine cases, suggesting men who commit these offences target some of the oldest and most vulnerable women (Dobash and Dobash, 2015). Nearly two-thirds of the offenders had previously been in prison.

2.3 Impacts, support needs and barriers to disclosing sexual violence

2.3.1 Impacts of sexual violence on older women

Since feminists began researching and campaigning around sexual violence in the 1960s and 1970s, attention has been drawn to the devastating physical and mental impacts of rape and sexual assault and the support needs of survivors. These include depression, drug and alcohol misuse, fears and phobias, high levels of anxiety, and suicidal feelings (Chen *et al*., 2010; Machado *et al*., 2011; Westmarland *et al*., 2012). Negative health impacts include increased risk of high cholesterol, heart disease, stroke, and problems with their immune system (Smith and Breiding, 2011), while a range of mental health issues have been associated with rape and sexual assault including overall poor mental health, self-harm, suicidal thoughts, panic attacks (Zinzow *et al*., 2011; Westmarland and Alderson, 2013) and post-traumatic stress disorder (Cougle *et al*., 2011). Research also suggests a higher prevalence of drug or alcohol misuse (Booth *et al*., 2011; Westmarland and Alderson, 2013). Research by Campbell *et al*. (2001) found that women who have been raped re-live the trauma, suffer flashbacks, nightmares and thoughts that would not leave. Research has consistently highlighted links between sexual violence and eating disorders (Westmarland and Alderson, 2013). Furthermore, the impacts spread across survivors' lives, affecting employment (Loya, 2015; Westmarland and Alderson, 2013) and relationships (Littleton and Grills-Taquechel, 2011). 'Battered women' and

women who have been assaulted sexually are at an increased risk of committing suicide (Gelinas, 1983; Stark and Flitcraft, 1996). It is widely acknowledged that the needs of rape and sexual assault survivors are multiple and complex. However, the effects and impacts of sexual violence on older women have received very little research. The majority of studies have focused on the impacts on younger women as research samples have typically included those aged between 16 and 50.

The existing elder abuse research has highlighted a number of significant adverse consequences of elder abuse, distinguished from those associated with general ageing (Wolf, 1997; Wolf *et al*., 2002; National Research Council, 2003). Physical effects include bruises, welts and wounds including head injuries, broken bones and sores; persistent and chronic physical pain; dehydration and nutritional deficiencies; sleep problems; increased susceptibility to new illnesses and conditions and, crucially, increased risk of premature death (Anetzberger, 2004; Lachs *et al*., 1998; Lindbloom *et al*., 2007). In terms of psychological effects, research has identified high levels of distress and depression as well as increased anxiety, self-harm and post-traumatic stress disorder (PTSD) (Comijs *et al*., 1998; Pillemer and Prescott, 1989; Yan and Chan, 2012). Emotional distress, loss of self-confidence, social isolation and suicide attempts have also been highlighted (McAlpine, 2008; O'Keeffe *et al*., 2007).

Elder abuse has also been linked to an increased risk of alcoholism and substance misuse (Anetzberger *et al*., 1994; Hwalek *et al*., 1996). In a systematic review of the existing literature, Cook, Dinnen and O'Donnell (2011) report that older women who have experienced physical or sexual assault report greater psychiatric distress including PTSD, when compared to older women who have not experienced such events. One of the consistent findings across the research are higher levels of alcohol and substance abuse among older women who have a history of sexual assault compared to non-assaulted counterparts (Cook, Dinnen and O'Donnell, 2011).

Whilst sexual victimisation is devastating at any age, it has been suggested that it can be particularly harmful during advanced age when capacity to self-protect is low and vulnerability to injury is high (Ramsey-Klawsnik, 2004b). Although the association between sexual violence and subsequent negative impacts on psychiatric and physical health is well established in younger and middle-aged women, much less is known about the correlates and impacts of this type of trauma in older women. A small number of studies have shown that sexual violence within the context of an intimate relationship has significant adverse physical and psychological health outcomes, especially among older women (Fisher *et al*., 2010; Fisher and Regan, 2006; Mouton, 2003). Moreover, it is argued that the psychological injuries are higher when assault is perpetrated by someone expected to provide love, protection and support (Ramsey-Klawsnik, 2004b). Impacts reported include gastro-intestinal, genital trauma and musculoskeletal problems (Morgan Disney and Associates, 2000) broken bones, dislocated joints, pelvic problems (Stöckl and Penhale, 2015) as well as depression and anxiety (Fisher and Regan, 2006; Soares *et al*., 2010) and overall poor mental health (McGarry *et al*., 2011; Mouton, 2003).

Although not a homogenous group, Jeary (2005) states that a common factor among elderly women considered in their study, who survived the attack, was the devastating impact which the sexual abuse had on them. According to Jeary (2005) the majority of survivors suffered long-term, life changing effects, including: feeling unable to continue living in their home; being generally fearful; being unable to sleep at night; having nightmares; requiring painkillers as a result of the injuries; suffering incontinence since the assault and other associated physical problems. Furthermore, as discussed in the previous chapter, genital trauma is more evident in the postmenopausal sexually assaulted women than it is in younger women, although as with younger women, rape may occur without injury (Cartwright and Moore, 1989; Eckert and Sugar, 2008; Poulos and Sheridan, 2008). The comparative

study by Muram *et al*. (1992) of 53 women aged 55 and over and 53 women aged 18-45 reported that more injuries were found in the elder group (51 per cent) than the younger group (13 per cent) but reported that genital injury was greater in the elderly women due to the postmenopausal status of the genital anatomy rather than any offender-associated factors.

The impacts of sexual violence in residential care settings specifically have not been extensively examined, however Burgess *et al.* (2000) reported over half the victims died within a year of trauma related complications such as physical injury and shock in her study. This does not necessarily indicate cause and effect as other factors, for example pre-existing health problems and the general older age of victims, might also be contributors, but the impacts on mortality require further specific examination in future research.

2.3.2 Support needs

Given the dearth of literature examining the impacts of sexual violence on older women, it is unsurprising that there is little available research which specifically looks at the support needs of older survivors of rape. One study from 1997 suggested that the treatment of postmenopausal women who have been assaulted is 'basically the same as that of premenopausal women' (Ramin, 1997, p.67). Ramin does go on to suggest, however, that older women may require more thorough psychological counselling, although this is based on the assumption that older women 'may have difficulty in communicating and expressing her emotions' (p.70). It may be assumed that many older women would have specific needs related to poor health or disability, however Lundy and Grossman (2005) found that, contrary to popular belief, women aged 65 and over do not always have disabilities or special needs. Just 12.2 per cent of their sample (n=1,057) of women aged 65 and over accessing

services for domestic violence reported having a specific special need or disability at intake. Their study reports that very few had serious physical impairments despite the average age of their sample being 72. However, services might not always be available or offer themselves to older survivors. Jeary and Stevenson (2004) concluded that minimal, if any, services were offered to elderly victims in their study in respect of coming to terms with their traumatic experiences. However, no further studies have specifically examined support needs of older rape victims.

From the elder abuse field, Pritchard (2000) conducted a study into the needs of older women and the services available for victims of elder and other abuse. There were 31 key needs identified by victims in the study ranging from practical needs such as housing, food and warmth, money and benefits and general information, through to more emotional support such as to talk to someone, to be believed, to be listened to and to be given advice.

Also from the elder abuse field, Nerenberg (2008) suggests victims' service needs span a broad spectrum and range from preventing abuse by reducing isolation and dependency and enlisting help and support; responding to and stopping abuse through to legal interventions and removing victims from unsafe settings, providing information, advice and support; and helping victims recover from abuse by medical treatment or health care, group or individual counselling, legal actions to recover property, counselling and support services. A range of services were identified by Nerenberg (2008) including shelters, counselling, emergency funds, legal assistance, victim witness assistance programmes, mental health assessments, support services and guardianship. Nerenberg (2008) reported a number of key issues to providing these services, including inconsistent responses and inadequate services.

2.3.3 Barriers to disclosing sexual violence and accessing support

The research around disclosure and help-seeking of rape and sexual assault survivors is contradictory. According to HM Government (2007) 40 per cent of adults who are raped tell no-one about the assault and 31 per cent of children who experience sexual violence reach adulthood without disclosing the abuse. Other research has argued that, whilst the majority of rape survivors do not disclose to the police or other formal agencies, most survivors do disclose to someone, either friends, family or support services (Ahrens and Campbell, 2000). In particular, the number of women disclosing to specialist rape organisations and accessing support services has increased in the last few years. Rape Crisis saw an increase of 40 per cent in calls to its national telephone helpline in 2013 alone (Rape Crisis, 2013). Survivors of sexual violence are not a homogenous group and therefore the support needs of women who have been raped or sexually assaulted will vary from individual to individual. However, a number of common support benefits have been identified, including counselling (Westmarland and Alderson, 2013) and support from advocates (Campbell, 2006). For example, on average, 71 per cent of women who received face-to-face counselling at Rape Crisis South London (RASASC) reported feeling able to make positive choices and live healthier lives (Fawcett Society, 2012).

There is a dearth of data on the number of women who access specialist rape support organisations. A study by Kelly *et al*. (2005) looked at data held by a Manchester Sexual Assault Referral Centre (SARC), St. Mary's, and found that, since they started collecting data on service users in 1987, the proportion of women aged over 45 accessing their services had remained relatively constant at five per cent of their total age profile of service users. The only SARC with available demographic data on service user profiles is the Treetops centre annual report (2008/09 report), which identified the

biggest age group of service users was 16-20, with just three per cent of service users aged 51 and over and zero per cent over the age of 70. However, based on the available research data, it is estimated that between one per cent and seven per cent of women over the age of 50 (see Chapter 1) experience rape or sexual assault and therefore these service user profiles referred to here show that there is significant under-disclosure of older survivors of sexual violence to support organisations. Literature from the elder abuse and domestic violence fields suggest underreporting might occur for a number of reasons, including: lack of awareness of abuse; physical and mental health issues; lack of awareness by health care professionals (Ramsey-Klawsnik, 2004a); referrals to inappropriate services and organisations (Jeary, 2005); media focus on younger victims of sexual violence and a lack of campaigns and advertising by support services which include, or are targeted at, older women (Desmarais and Reeves, 2007).

A study by Wolf and Pillemer (1994) reported the three most common barriers to community service utilisation by elder abuse victims were: the fragmented service system; reluctance of victims to accept services; and the shortage of trained personnel. Conversely, Barker and Himchak's (2006) study examined the key factors influencing the utilization of services by 129 elder abuse victims who were living in the community. They found there were three 'need' factors influencing the decision to engage with services: (1) victim has cognitive and active daily living impairments; (2) victim has poor health status (self-rated); and (3) the abuser is financially dependent on the victim and is also the primary caregiver of the victim. The main 'enabling' factor for service engagement was that the victim lived alone.

A recent study in Australia conducted by Mann *et al*. (2014) aimed at increasing awareness and understanding of the settings, social contexts and vulnerabilities associated with the sexual assault

of older women. The study found a number of issues, barriers and challenges which combine to silence older women who experience sexual assault, both in the community and care homes. Through qualitative surveys and interviews with practitioners in age related and sexual violence related organisations, family members of older women who had been sexually assaulted, community members, including some older women, the study found that sexual assault took place in a number of everyday settings (homes, domestic contexts, public spaces and so on) as well as institutional settings such as care homes or retirement villages. A number of key factors within these settings contributed to sexual assault, namely: society/cultural issues such as sexism, ageism, power inequality; community/organisational factors such as organisational cultures, structures and training, devaluing older citizens, denial and silence and social isolation; and family/individual factors, including frailty, disability, cognitive impairment, family violence, attitudes and beliefs that support sexual violence. All of these factors contribute to the sexual assault of older women and act as barriers to them disclosing abuse, reporting to the police or seeking support from family, friends or professionals. However, the study did not include survivors themselves so is limited to the perceptions of workers and family members.

The literature on domestic violence in later life has reported similar barriers to disclosure. These centre on generational and cultural norms and practices, isolation, dependence and shame. Generational attitudes and understandings of abuse are reported as a key issue. Many women may not recognise what they are experiencing as abuse, having accepted and normalised the behaviour throughout their relationship (Scott *et al*., 2004). Older women come from a time where you were expected to keep matters private (Straka and Montminy, 2006), and have been socialised with more traditional attitudes and values relating to gender roles, marriage and family (Straka and Montminy, 2006). These could include a strong sense of privacy about family issues, being a good submissive

wife and being committed to their husband and family (Aronson, Thornewell and Williams, 1995). In addition, fear that disclosure will exacerbate abuse (Women's Aid, 2007) and a lack of awareness of appropriate services (Beaulaurier *et al*., 2007) have been reported.

Several studies have found that shame and stigma are huge barriers for older women. Women may experience shame due to the marriage breaking down and not being able to fix the relationship, and also for putting up with the abuse for so long (Scott *et al*., 2004). Other issues include a lack of awareness about abuse against older women in society and particularly by health and social care professionals, including GPs, nurses and mental health workers, pose significant difficulties for older women. As a result of the blurred distinction between elder abuse and DV, Brandl and Horan (2002) found that women were being offered inappropriate support which included family counselling, offering support for the perpetrator and/or anti-depressant prescriptions for the woman. Furthermore, the professionals' attitudes, rather than being supportive, often blame the victim (Pritchard, 2000). Moreover, Brandl *et al*. (2003) found that support programmes in the USA, whilst open to women of all ages, may focus primarily on issues related to younger age such as child custody or job training and may not be accessible or appropriate for older women.

Isolation is another key barrier facing older women. This can be economical or social (Schaffer, 1999). This might be further compounded for women who live in rural areas where traditional views and values are held, 'small town' culture and geographical challenges include lack of access to services, public transport or friends/family (Schaffer, 1999). This overlaps with physical dependency on the abuser or the abuser's dependency on the woman because of ill-health (Flueckiger, 2008; Wolf, 2000).

Older women may not be aware of their legal and financial rights, or the resources available to help them and there is a distinct lack of appropriate services available to older women. Campaigns by the police, government and specialist DV agencies tend to focus on young women and men, which may lead older women to believing these services are not open to them (Scott *et al*., 2004). Several studies have documented that a lack of suitable housing is a key issue for older women, who may not want to live in a refuge environment with younger women and children, or may require ground floor rooms and who are reluctant to leave the family home and communities which they love (Penhale and Porritt, 2010; Scott *et al*., 2004; Zink *et al*., 2003).

Many of the issues facing older women are the same as those facing younger women - safety, suitable housing and economic independence - however, older women may face different barriers to services and therefore may need similar services delivered differently (Scott *et al*., 2004). Morgan Disney and Associates (2000) documented that the kinds of impact of abuse, on women, are broadly similar across age groups but that some affect older women more adversely or have different ramifications for them. Compared with younger women, older women have more years invested in their families and communities and less opportunities in terms of education and work (Zink *et al*., 2003). This means they have more to lose by leaving, which is compounded by the issues and barriers they face. Furthermore, years of physical and/or emotional abuse may have reduced the woman's confidence and may intensify the shame and embarrassment the woman feels (Zink *et al*., 2003).

There is a dearth of literature related to the experiences of older minority ethnic women and barriers they may face in disclosing abuse or reporting to the authorities. One study by Burman *et al*. (2004) reported that cultural misconceptions and normalisation of certain behaviours were barriers for older women accessing support, however there remains a lack of research examining these issues.

One criticism that has emerged from the domestic violence against older women research is that there is a lack of awareness of the support available for older survivors (Scott *et al*., 2004; Macdonald, 2001; Brandl and Horan, 2002). This is in part attributed to a societal ignorance of violence affecting older women (Scott *et al*., 2004). There is a lack of available services for older victims of domestic violence, however a number of organisations have recognised this gap and have developed age-specific services. For example, Eva Women's Aid based in Redcar in the North East of England opened the first dedicated refuge for women aged 45 and over in 2015. In London, Solace Women's Aid in London ran a specific service for those aged over 55, The Silver Project, between 2010 and 2013. However, there remains a national gap in relation to services specifically designed for older victims.

2.4 Perpetrator characteristics and motivations

2.4.1 Perpetrators of sexual violence against older women

Whilst there is a considerable body of literature examining sexual offending, and offenders, a review of this literature was outside of the scope of this thesis. Instead, the focus of this section is on the limited existing research specifically on sexual offenders against older adults. A small number of studies have specifically examined perpetrator characteristics and the findings are inconsistent. Burgess *et al*. (2007) argue that one of the few indisputable conclusions about sexual offenders is that they constitute a markedly heterogeneous group. The childhood and developmental histories, adult competencies, criminal histories of sexual offenders and the motives and patterns that characterise their criminal offences differ considerably.

The research findings on the age of offenders who sexually abuse older women range from very young (under 16) to the same age or older than victims. Early studies suggest perpetrators of these crimes tend to be very young, leading to terms such as 'gerontosexuality' (a preference for sexual relations with elderly partners) and 'gerontophilia' (a sexual disorder referring to adolescents who make aggressive attacks on older women with a view to raping or sexually assaulting them) used to describe perpetrators (Ball, 2005). Groth (1978) was one of the first to look at offender characteristics in rape cases involving older women (aged 50 or over), examining 170 sexual offenders referred to a forensic psychiatric facility in Massachusetts, USA. His analysis revealed that 25 per cent of the victims were 30 or more years older than the offender. The offenders were predominantly young, white single males ranging in age from 12 to 38.

Recent studies have also found a significant number of perpetrators of rape or sexual assault against older women are considerably younger than the victim. In the UK, Jeary (2005) evaluated sexual offending against elderly women aged between 60 and 98 years at the time of the offence, ranging from sexual harassment to rape. A total sample of 52 cases involving 54 victims were selected, based on data drawn from prison and probation services and social services at a national level. The offenders were aged between 16 and 70 plus and in the most serious sexual offences (rape/attempted rape, sexual assault and killing) two thirds of the perpetrators were aged between 16 and 30 years. Similarly, Burgess *et al*. (2007) considered offender characteristics in rape cases involving older women aged 60 and over and reported an age range of offenders between teenagers and aged 60 plus. The majority of offenders were aged in their early 20s at time of offence, however 10 were teenagers. Only one offender was aged in his 50s and one in his 60s at the time of the offence.

However, other studies have not observed significant age differences. Ball and Fowler (2008) conducted a cohort study based on a population sample of police recorded sexual offences in a semi-rural English county. When looking at the entire study sample, there were 12 cases (12.5 per cent of all female victim offences) where the reported male perpetrator was at least 30 years younger than the victim. In these cases, there were a total 15 offenders (thus multiple offenders in some cases) with an age range of 13-28, a mean of 19.33 years. A recent study by Pinto *et al*. (2014) reports an average perpetrator age of 47.7, compared with a mean age of 77.1 for victims. Thus, perpetrators were, on average, significantly younger than victims in both studies.

However, other research has not found a significant number of offenders to be very young compared to the victim. Roberto and Teaster (2005) compared circumstances and outcomes in sexual abuse cases against young and older women, based on aggregated data from the Adult Protective Services in the Virginia, USA (n=125). Four cohorts were identified in the sample ranged from 18 years to 80 and older. A total 78 of the sample were aged 60 or over (63 per cent). Furthermore, in a UK study, Lea *et al*. (2011) compared 39 rape or sexual assault cases involving older women with 46 cases involving younger female victims aged 20-45 and found there was no statistical significance in terms of the offenders' age between the two groups. It is therefore unclear from the existing studies whether perpetrators are more likely to be younger than victims.

Several studies have found perpetrators have low levels of education and high levels of unemployment. Research conducted in Ireland by Collins and O'Connor (2000) examined 10 cases of sexual assault against women aged 65 and over and found that nine of the 10 offenders had a criminal history for nonsexual crimes whereas four had a history of sexual offences. This was also identified in Ramsey-Klawsnik's (2004b) study which found one typical 'profile' of adult son

perpetrators of elder sexual abuse were those who were unmarried, unemployed or under-employed, and who resided in the home of an elderly parent and were financially support by that parent. Such perpetrators often display poor social, occupational and financial functioning and often substance abuse or mental illness (p.50). The existing research findings report a significant minority of convicted male offenders who have committed sexual offences against older women also have previous convictions for assaults against children and younger women (Lea *et al*., 2011; Del Bove *et al*., 2005).

However, other research contradicts these findings. For example, Pollock (1988) compared five solved sexual assaults against female victims aged 60 and over with seven cases of sexual assault against women aged between 16 and 30 (which mirrors the age group argued to be most at risk, according to Home Office statistics). A number of variables were compared but no significant differences yielded in respect of offender criminal history, offender relationships to the victim, use of weapons, level of violence, location of offence and substance abuse. However, this study is limited by the small sample and several of the cases were homicides which may involve different characteristics to cases of rape and sexual violence where the victim is not killed.

A UK study by Lea *et al*. (2011) compared offender history between younger and older victims and found offenders who assaulted older victims (n=53) had significantly more previous convictions than those who assaulted younger victims. They report that offenders who assaulted older women had significantly more juvenile previous convictions, previous convictions for offences against property, previous convictions for theft and previous convictions for sexual offences than did offenders who assaulted younger victims. In a more recent study in Portugal, Pinto *et al*. (2014) examined 14 cases of sexual violence involving an older victim, more than half of the perpetrators had at least one

previous conviction ranging from drug offences and robbery offences through to sexual offences, some of which were also against older women.

Very little is known about the other characteristics of perpetrators. Lea *et al*. (2011) is the only UK study to also consider ethnicity differences in victims and offenders. They report significant findings in relation to ethnicity of offender and age of the victim, in their comparison of young and older victims of sexual assault by strangers. They found 94 per cent of their sample of offenders who assaulted older victims were white and six per cent were black, compared to 72 per cent white and 28 per cent black offenders who assaulted younger victims. However, this study specifically looked at sexual assault by strangers and this data is therefore unlikely to be generalisable to all victims' older victims of rape or sexual assault, particularly where the violence takes places in the context of an intimate relationship.

2.4.2 Motivations of perpetrators of older sexual violence

Understanding the reasons why men rape and examining the motivations of individual and groups of offenders have been key areas of scholarship across criminological, psychological and feminist research. Feminist understandings of the cause of rape being rooted in a patriarchal society where women face systematic inequality and men hold the dominant powerful positions have been influential in shaping our understandings of sexual violence and perpetrators. Similarly, previous theories around caregiver stress causing elder abuse (Steinmetz, 1988) have been debunked and it is now generally accepted that elder abuse is rooted in unequal power relations, societal ignorance and ageism of older people, control, and a relationship history between the victim and perpetrator (Anetzberger, 2012; Brandl and Raymond, 2012; Straka and Montminy, 2006; Whittaker, 1995).

As the World Health Organisation (n.d.a) points out, 'while the popular image of abuse depicts a dependent victim and an overstressed caregiver, there is growing evidence that neither of these factors properly accounts for cases of abuse' (p. 131). Given the majority of safeguarding referrals involve a female victim (HSCIC, 2014) and research has shown women are victims of elder abuse in the majority of cases (Aitken and Griffin, 1996; Lachs *et al*., 1998; Dunlop *et al*., 2001; O'Keeffe *et al*., 2007; Naughton *et al*., 2010) it is clear women are at significantly higher risk of victimisation, whilst men continue to be the majority of perpetrators and as such, feminist theories on abuse of women generally would appear to be relevant to the understanding of elder abuse (Whittaker, 1995; Penhale, 2003). However, given some of the characteristics of offences involving older victims reported in the existing literature differ from the general understandings of sexual violence (i.e. perpetrators of offences being significantly younger than the victim; a higher number of cases involving perpetrators who are strangers and so on) some research has attempted to develop typologies, and identify motivations, of perpetrators of sexual violence against older women.

Burgess *et al*. (2000; 2007) suggest there are three types of offenders who commit sexual assaults against elderly women: those who seek jobs in nursing homes with the aim of preying on the residents; elderly men who reside in nursing homes and assault fellow residents; and individuals who assault women who live independently. However, this description on the types of perpetrators lacks one important group; intimate partners. Research suggests that the majority of women are raped by someone they know (86 per cent) and in most cases it is a partner or ex-partner (Home Office, 2013) and therefore it is reasonable to assume this would also be the case for older victims.

Some research has looked at motivational factors and characteristics of offenders. Jeary (2005) identified four motivational factors and two characteristics. The motivating factors were: financial; self-focus and countering sexual inadequacy; sexual gratification and sexual fantasies; and power, control and revenge. Financial motivation typically applied where the offences initially appeared to have been burglaries for the purpose of financing drugs or alcohol. Jeary (2005) reported that, in her study, offenders targeted 'sheltered' housing - housing that has been specifically chosen to increase their personal safety and sense of well-being - because security might be inadequate and it was likely that cash would be in the house.

Self-focus and countering sexual inadequacy was the second category. A recurring theme in Jeary's (2005) study was an inability to perform sexually in age-appropriate relationships, and this applied across the age-range of offenders. Some offenders reported seeing the sexual offence against the elderly woman as a means of testing out their sexual performance and their failure then often triggered excessive violence towards the elderly woman. Elderly women were chosen as victims because of the decreased risk of them being able to resist, to mock or to report on their sexual performance. Jeary (2005) describes these offenders as being self-absorbed, with their sexual thoughts revolving entirely around themselves.

The third category, sexual gratification tied into the self-absorption that Jeary (2005) identified. Sexual gratification was the primary motive for several offenders in this study. These cases included intra-familial and 'stranger' rape. In some cases, young men had broken into elderly people's homes. In court and prison reports, several offenders admitted to having sexual fantasies about middle-aged and elderly women and using pornographic images of elderly people as masturbatory stimuli.

Power, control and revenge were frequently recurring themes in Jeary's (2005) research, factors also reported in earlier studies by Groth (1978) and Cartwright and Moore (1989). Many demonstrated difficulties with forming and/or sustaining age-appropriate relationships or emotional attachments, perceived themselves to be inadequate sexually, had long-standing pre-occupations with sexual matters and generally had low self-esteem. A further recurring theme was the offender seeking to get revenge for treatment of themselves previously by the victim or other women. There were a number of reasons underpinning this, including previous experiences of criticism by either the victim or another woman. However, the most frequently recorded source of desire for revenge stemmed from a history of physical, sexual or psychological abuse experienced when they were children, by adults with some form of caring responsibilities towards them.

The two themes were childhood abuse and sexual abuse of elderly people and children. In 50 per cent of the cases in Jeary's (2005) study, the perpetrator reported at some stage being physically or, more often, sexually abused as a child. The majority of this abuse was intra-familial. Jeary is careful to warn, however, that this is not suggesting a cause and effect relationship between childhood abuse and the victim going on subsequently to offend, as the other 50 per cent of offenders did not report experiencing any abuse. Furthermore, of those who did report, they may have done so to mitigate court proceedings, as self-justification for, and minimisation of, deviant behaviours. The second theme, sexual abuse of both elderly people and children, was present in around 20 per cent of cases. These offenders, convicted of sexual offences against an elderly person, also had previous convictions for sexual offences against children.

Burgess *et al*. (2007) also considered motivation and severity of the sexual violence against older women through interviews with twenty-five convicted rapists in prison. The findings were grouped into four primary motivational dimensions: opportunistic; pervasive anger; sexual; and vindictive.

The opportunistic motivation refers to an impulsive rapist type who shows little planning or preparation. The rape is for immediate sexual gratification in the service of dominance and power. In this study, the majority of rapists categorised as opportunistic claimed not to have penetrated the victim, but rather committed acts of fondling, kissing and molestation.

The pervasive anger motivation referred to offenders where the degree of force used in the assault is excessive and gratuitous. The violence is an integrated component of the behaviour even when the victim is compliant. The rage is not sexualised, suggesting that the assault is not fantasy-driven. The violence is a lifestyle characteristic that is directed toward males and females alike.

In the 'sexual' category, there is a high degree of preoccupation with gratifying one's sexual needs and are typically evidenced by highly intrusive, recurrent sexual and rape fantasies, frequent use of pornography, reports of frequent uncontrollable sexual urges, use of a variety of alternative outlets for gratifying sexual needs. The sexual assaults of these offenders are often well planned, as evidenced by clear, scripted sequence of events, possession of assault-related paraphernalia and an apparent plan to procure the victim and elude apprehension after the assault.

In the final category, vindictive motivation, the core feature and primary motive is anger at women. Unlike the pervasive anger type, women are the central and exclusive focus of the vindictive rapist's anger. Their sexual assaults are marked by behaviours that are physically injurious and appear to be

intended to degrade, demean and humiliate their victims. As noted, these types differ to pervasive anger in that they show little or no evidence of anger towards men.

Whilst it may be useful to categorise offenders to examine patterns in offending, this research was based on a small number of offenders and arguably would not apply to sexual violence that occurs in other contexts, such as intimate relationships. Furthermore, there has not been a developing body of research since Jeary and Burgess which has examined these theories across other samples of offenders who have committed sexual offences against older women.

2.5 Summary

This chapter has given an in-depth review of the literature from three fields: sexual violence, domestic violence and elder abuse on the extent, nature, impacts, and perpetrators of sexual violence against older women. The following chapter will now turn to the methodology, methods and the ethical considerations followed for carrying out this mixed-methods study, which sought to address the current gaps in knowledge.

Despite the plethora of research examining sexual violence there is little empirical evidence examining the extent, nature and impacts of sexual violence against older people, or the perpetrator characteristics and motivations of these offences. The existing research is limited by a lack of studies including, or specifically focusing on, older survivors. The national data is limited by the age cut off of 59 in the CSEW and both small and larger scale studies examining rape in the UK and elsewhere has generally focused on younger populations. This is largely because national data has consistently revealed that women aged between 16 and 30 are at the highest risk of being raped. There is therefore a lack of data on the prevalence, impacts and support needs of older people, which may

have implications for survivors and organisations. Moreover, there is a lack of research exploring the impacts, coping strategies and support needs of victims of elder abuse and few studies have given voice to the experiences of victims. For example, assumptions that older adult victims with diminished capacity or other impairment have lost their right to self-determination and autonomy, or that abuse and neglect always reflects a power and control relationship between abuser and victim, limit the ability of the researcher to generate heuristic findings. There are also issues with the current theoretical approaches to understanding elder abuse. From a feminist theoretical framework, elder abuse can be conceptualised as similar to the power and control dynamics of younger battered women (Harris, 1996) based on the same coercive patterns and tactics to gain and maintain control over the victim (Brandl and Raymond, 2012).

More recently, however, this has begun to be acknowledged; research, particularly in domestic violence studies, and 'elder abuse' has gained increasing research attention. Although useful findings have been yielded, these studies suffer from several methodological weaknesses, including a lack of consistency in defining 'older' and small convenience samples accessed through agencies and thus being limited to women already accessing support (for a review see Weeks and LeBlanc, 2011). Furthermore, although sexual violence is included in the definition of domestic violence in England and Wales the existing studies exploring DV against older women have predominantly focused on other forms of abuse, namely physical violence, emotional and financial abuse. Furthermore, those from minority groups, such as black or ethnic minority women, those in the traveller community and asylum seekers have not been included in the majority of research so little is known about the extent, impacts and support needs across, and within, these populations. Moreover, the existing research has almost exclusively focused on older female victims of domestic violence, so little is known about male experiences. This research aimed to begin to address some of these gaps.

Chapter 3: Methodology and methods

3.1 Introduction

This research used a mixed-methods model which consisted of three phases: Phase 1 was the collection and analysis of quantitative data held by police forces in the UK gained through Freedom of Information (FOI) requests; Phase 2 was qualitative interviews with 23 practitioners working in sexual or domestic violence organisations (the majority of whom offered services to women), and four practitioners working in age-related organisations, to examine the perceptions of these workers of the challenges and barriers older people face in disclosing and accessing support, the impacts of rape on older people and the current gaps in services; Phase 3 involved qualitative case studies of three women who have experienced rape since the age of 60 to explore the impacts of rape, their experiences of accessing services, disclosing or reporting their experiences, the barriers and challenges they faced, and any gaps in services. In Chapter 1.3. the overarching feminist framework was outlined, drawing on gerontology and intersectionality theories. The methodological approach of the research aligns with the theoretical framework (Chapter 1) and draws heavily on feminist approaches to conducting research.

Sexual violence is widely regarded as a 'sensitive' topic to research (Downes *et al*., 2014), and there has been significant attention paid to the methods used to research this topic, particularly where the research involves survivors. Whilst qualitative methods, particularly qualitative interviews, have traditionally been the preferred method in feminist research, there is now recognition that quantitative methods can be appropriate for researching sexual violence either as stand-alone methods or in combination with qualitative methods (mixed-methods). There has been a shift away from the belief in a single method which is inherently 'feminist', to the view that the research

method(s) should be the most suitable to address the aims and research questions of a particular project and the needs of the particular population being researched.

This chapter provides an overview of the development of mixed-methods approaches in feminist research before outlining the research design, specifically the three phases of empirical data collection and the corresponding methods and process of analysis. Reflections on the use of these methods, particularly Freedom of Information (FOI) requests are provided and how this was utilised as part of a mixed-methods model is explained. This chapter closes with a reflection on the experience of conducting the project and some of methodological and ethical considerations encountered along the way. Reflections on interviewing older women as a young, female researcher are provided, specifically being an 'outsider' and managing the emotional impacts of conducting this type of research. However, first it is worth briefly recapping on the research aims and questions.

3.2 Aims, objectives and research tools

This doctoral research had two clear aims. First, the research aimed to examine the prevalence and nature of rape and serious sexual assault against older women who have been raped or sexually assaulted since the age of 60. Second, this research aimed to explore the impacts of rape and sexual assault against older women and the services needs they present, with particular focus on the extent to which these needs can be met through existing support provisions.

In line with these two overriding aims, the following research objectives were formulated:

1. To analyse the extent of police reported and recorded sexual violence against older people in the UK

2. To examine the nature of sexual violence against older people, including victim, perpetrator and offence demographics
3. To explore whether older women's experiences of sexual violence and the impacts differ from younger survivor's experiences
4. To examine the factors that influence older survivors' decisions to report sexual violence to the police or support organisation
5. To explore the support needs of older people who have experienced sexual violence since the age of 60
6. To explore whether staff and volunteers at specialist sexual violence organisations (e.g. Rape Crisis) and specialist age related organisations (e.g. Age Concern; Action on Elder Abuse) feel competent in their ability to meet the needs of older women disclosing sexual violence.

3.2.1 Methodological Approach

Methodology specifies how social investigation should be approached (Ramazanoglu and Holland, 2002, p.11). It is a combination of theories and analyses of how research should proceed (Harding, 1987; DeShong, 2013, p.3). Methods are researching tools but are linked to and stem from methodologies (Giddings, 2006), which are in turned shaped by specific ontologies and epistemologies (Darlaston-Jones, 2007). Ontology is the nature of reality (Creswell, 2003) whilst epistemologies are how we study reality. As discussed in Chapter one, this doctoral research is rooted in a feminist theoretical framework and adopts a feminist methodological approach, exploring ageing as an overlying characteristic of oppressive female experience due to one dominant experience: sexual violence. The idea of situated knowledge is central to feminist epistemology, which views reality as a social construction; people experience the world with their body and mind. Feminist

epistemology challenges the quantitative and qualitative 'malestream' social research and provides a platform for marginalised groups to have their voices heard (Ramazanoglu and Holland, 2005). This is suitable for this research as older survivors have been primarily marginalised and hidden in the existing literature (see Chapter 1.3).

As there is no unified feminist theory, there is also no single feminist methodology. Scharff (2010) stresses that when adopting a feminist methodological framework 'it is crucial to bear in mind that feminist research is a 'perspective' (Reinharz and Davidman, 1992, p.84) rather than a clearly defined set of methods. As Ramazanoglu and Holland (2002, p.10) point out, 'feminists are divided over where ideas come from, how people make sense of their experience and what evidence is evidence of'. Rather than offering a distinct methodology, feminist research and scholarship provides the researcher with a broad methodological and ethical framework for conducting research with women, for women. Some shared commitments among the different approaches include: being reflexive on the research process and the researcher's role within that process; reducing or removing the power hierarchy between researchers and participants, particularly in qualitative interviews; how to make sense of, and interpret, the knowledge developed in the research and how to use that knowledge to inform practical developments that benefit women (Ramazanoglu and Holland, 2002; Oakley, 1988; Campbell and Wasco, 2005; Dickson-Swift *et al*., 2007; Skinner *et al*., 2005). Feminist research is committed to removing this hierarchal relationship through methods which allow for reflexive, reciprocal dialogue, which prioritises the lived words and experiences of participants and minimises the potential for participants to be simply 'used' as a tool in the data collection process.

Qualitative methods have traditionally been the preferred research methods of feminist researchers to achieve the commitments outlined above. Quantitative methods were aligned with 'malestream'

social research which prioritised an objective, positivistic approach to research and as such were largely rejected by the feminist movement, leading to something of a paradigm war (Oakley, 1999). 'Malestream' social research was criticised for not fully incorporating women and thus the knowledge provided by conventional epistemological approaches did not relate to women or their concerns (Tolman and Szalacha, 2004). As Bryman (1988) notes, quantitative and qualitative methods have generally been portrayed as mutually antagonistic ideal types, representing as two different paradigms of social science itself. Feminist criticisms of quantitative methodology were made on several grounds: that the choice of topics often implicitly supports sexist values; that female subjects are excluded or marginalised; relations between researcher and researched are intrinsically exploitative; the resulting data are superficial and overgeneralised; and quantitative research is generally not used to overcome social problems (Oakley, 1998, p.709). Furthermore, quantitative research has been argued to present a distorted view of the world, dominated by male ideology and limited by issues such as reliability and representativeness (Sarantakos, 2012). Thus, feminist research was generally considered to be different from, incompatible with, and critical of, conventional quantitative social research and science (Sarantakos, 2012).

Initially then, the feminist contribution to discussion of research methods focused on qualitative research techniques (e.g. Finch, 1993; Oakley, 1981), but, subsequently, feminists have also argued that quantitative research methods have a role to play within feminist methodology (Sampson *et al*., 2008; Kelly *et al*., 1994). The sole reliance on qualitative methods has been challenged by a number of feminist researchers since the 1990s (see, for example, Gelsthorpe, 1992; Maynard and Purvis, 1994, Westmarland, 2001), and the use of quantitative research methods in feminist research has been evidenced and documented (Jayarantyne, 1983; Walby and Myhill, 2001). As Sarantakos (2012) argued, it is often taken for granted that feminist researchers take an anti-quantitative position and

therefore abstain from quantitative standards and principles of research, including validity, objectivity, reliability and generalisation. She points out that, while some feminists may take this position, in the majority of cases, this assumption is not correct.

The need to move beyond and close the paradigm war between quantitative and qualitative approaches has been argued by Oakley (1999). Rather than arguing that qualitative methods are the only methods suitable for feminist research, Oakley suggests the key issue for feminist researchers is to obtain a more critical and ethical approach to all kinds of methods, whether quantitative or qualitative (p.302). Ultimately, it is increasingly acknowledged that the difference between feminist and non-feminist research lies not in the type of methods they use, but rather in the way they choose, change and use conventional methods to meet their research goals (Kelly *et al*., 2005; Sarantakos, 2012). A significant number of feminist researchers now utilise a mixed-method approach, which is argued to benefit from providing the big picture and the personal story (Hodgkin, 2008). It has been argued in the existing feminist literature that feminist research, which draws evidence from a variety of sources, is more likely to be seen as valid as reliable, and thus more likely to be heard in the policy arena (Shapiro *et al*., 2003).

There are four primary advantages to using quantitative methods in feminist research (Miner-Rubino and Jayaratne, 2007). First, quantitative methods such as surveys can introduce social justice issues, such as racism, sexism or ageism, into the mainstream discussion in public policy arenas; second, statistics and numbers can be more concise and therefore can be easier to remember and communicate to others; third, quantitative methods can be useful in identifying patterns in women's oppression which can then be used to inform policy and social change; finally, methods such as

surveys can access large numbers of people and can therefore potentially represent a wider population from multiple perspectives (Miner-Rubino and Jayaratne, 2007).

However, whilst quantitative methods can provide the 'bigger picture' of social problems, qualitative methods are more suited to telling the 'personal story', and increasingly social researchers, including feminists, have been realising the benefits of mixing quantitative with qualitative methods (Hodgkin, 2008; Gilbert, 2006; Denscombe, 2008). Combining methods such as questionnaires with interviews allows feminist criminological researchers to examine the extent of violence as well as the lived experiences of those who have been a victim. Furthermore, as Reinharz and Davidman (1992) point out, a mixed-method approach increases the likelihood that researchers will understand what they are studying and be able to persuade others of the veracity of their findings.

A mixed-method quantitative/qualitative approach was adopted to address the central aims and objectives of the research, which was divided into three phases: the first phase involved quantitative analysis of primary data collected through Freedom of Information (FOI) requests to individual 45 police forces in the UK; the second phase involved qualitative interviews with twenty-three professionals at sexual and domestic violence related organisations; the third phase involved qualitative interviews with three older survivors of rape or sexual assault. However, as Kidder and Fine (1987) have argued, different methods within different paradigms are addressing different questions (rather than addressing the same questions differently), leading to different knowledge and interpretations.

Consequently, data collection and analysis can often be conflicting and can result in a fragmented research project. A sequential approach addresses these issues as the data collected in one phase

contributes to the data collected in the next and each phase is used to inform the next (Driscoll *et al*., 2007). Reflections on this approach are provided later in section 3.3.7.

3.3 Quantitative data collection

The quantitative stage in this study pertains to Phase 1, which used Freedom of Information requests to all 46 police forces in the UK to examine the extent of recorded rape and sexual assault by penetration offences involving a victim aged 60 or over (Research Objective 1) and the nature of the offences, examining victim, perpetrator and offence demographics and characteristics (Research Objective 2).

There is no national register of recorded rape and serious sexual assault offences[2] (Feist *et al*., 2007). Although the Police National Computer holds data on people who were, and are currently, of interest to law enforcement agencies, it does not hold data on victims, or of recorded offences where no offender has currently been identified. Furthermore, there is no single national database used by police which holds data on reported offences, and therefore the software and systems used by individual forces across England and Wales vary substantially. In theory, the details recorded by the police should be consistent (although they may be recorded in slightly different ways or on different computer databases) based on the Home Office Counting Rules (HOCR) which work in conjunction with the National Crime Recording Standards (NCRS).

[2] With the exception of the Serious Crime Analysis Section as part of the National Crime Agency which manages a national database that holds the details of serious sexual attacks by strangers which is based on case files sent by police officers across the UK.

According to the NCRS, an allegation of rape should be considered made at the first point of contact and it is a national requirement that an incident should be recorded as a crime within a standard timescale of 24 hours from the time the incident is first logged (Home Office, 2016). If the police decide, on the balance of probabilities, that a crime did not take place within the 24-hour timeframe they have for investigating, the allegation is never crimed. The approach is now victim-focused and the belief by the victim, or person acting on behalf of the victim, that the crime occurred should usually be sufficient to justify its recording as a crime. Moreover, the normal rules around No Further Action (NFA) incidents which allow police to end an investigation with referral to the Crown Prosecution Service (CPS) for a charging decision do not apply to rape cases; all rape cases (as with all indictable only cases) and those matters listed in the Director's Guidance as exceptions to police charging decisions, must be referred to a prosecutor to consider whether a decision to NFA the cases should be made on Public Interest grounds (Home Office, 2016).

As part of the recording process, the police are encouraged to take as many details of relevant information as possible (ACPO, 2005). This may include the location and time of incident, nature of incident, location and identity of victim and suspect if known, whether weapons have been used and if the suspect is known to the victim (ACPO, 2005). However, the exact data collected by individual forces differs and issues in data quality mean some information is more rigorously collected than others. Issues in missing data or inconsistent data between forces have been noted by researchers (Feist *et al*., 2007) and can cause complications when analysing data.

Police forces therefore hold data on recorded incidents which meet the requirements to be classified as a 'crime'. Whilst there is no national database with this information that members of the public can access, the Freedom of Information Act 2000 provides citizens with the ability to request data

held by the police. This tool is commonly used by journalists, however researchers have been slow on the uptake and there are few published studies documenting the use of Freedom of Information (FOI) requests in research. However, this is a potentially powerful tool for researchers and may be particularly suitable for feminist research projects which seek to examine issues affecting marginalised groups who may be difficult to recruit using qualitative methods. Nonetheless, as Camaj (2010, p.3) points out 'as a consequence of the strong culture of secrecy' the demand for access to information remains low (Banisar, 2006, p.26). The following section provides a brief history on the emergence of FOI and the legislation governing its use in the UK.

3.3.1 Freedom of Information requests in social research

Internationally, legislation and policy governing access to information is not a new development; Walby and Larsen (2012) point out that Sweden's Freedom of the Press Act of 1766 is the oldest existing form of access law and there are now as many as eighty countries with laws facilitating access to information. Furthermore, the 'global trend' of openness has seen a significant increase in the adoption of FOI laws across the world (Byrne, 2003) with more than 80 countries adopting some provisions providing citizens with the right to access information in 2006 (Banisar, 2006).

In the UK, the two pieces of legislation governing access to information are the Freedom of Information Act 2000 (England, Wales and Northern Ireland) and the Freedom of Information Act 2002 (Scotland). Under these acts, individuals and organisations are able to make requests for data held by public authorities. Importantly, applicants do not need to be citizens or residents in the UK to make a request (Lee, 2005). Public authorities include a range of organisations and institutions, including government departments, local councils, health service bodies (including the NHS), schools,

colleges, universities, police forces and associated authorities and the armed forces. Requests must be made in writing (email is accepted) and the authorities have a 20 working day timeframe within which to respond, either with the requested information or with a refusal, based on one of the exemptions contained in the acts. Authorities may also request an extension which can be granted by the researcher.

Authorities must provide the requested data in full (s10), and wherever possible, in the format requested, unless it falls within one of the exemptions contained in the act. As such, there is a positive obligation on the authority to release the data requested, and that is the starting point of the legislation. There are twenty-three exemptions in total, broadly categorised as 'absolute' and 'non-absolute'. There are six absolute exemptions: Information accessible to the applicant by other means (s21); Information supplied by, or relating to, bodies dealing with security matters (s23); Information relating to Court records (s32); Parliamentary privilege (s34); Information provided in confidence (s41); and Information prohibited from disclosure by any other piece of legislation or enactment (s44). For absolute exemptions there is no requirement to apply the public benefit test, however, for the remaining 17 non-absolute exemptions, a public benefit test must be applied, which seeks to assess the balance of the public interest for and against disclosure. If an authority refuses to release the requested information because it believes it to be exempt, it must provide the applicant with the reasons for this and inform them of the right to complain to the Information Commissioner who regulates the Acts. As such, despite the positive obligation on public authorities to release information which is, by virtue, considered public information, those working in FOI teams or roles act as gatekeepers to the information and the broad range of exemptions can provide a basis for refusal of the information in a multitude of situations. These issues are discussed in detail further on in this paper, with particular reference to negotiating with gatekeepers (section 3.3.5).

Applicants can request an internal review if they are unhappy with the way their request has been dealt with, either because of delays in providing the information or refusals to provide some or all of the information requested. If they are still unhappy after the internal review, they can complain to the Information Commissioner.

The acts have proven a useful tool for individual citizens and journalists. According to the Ministry of Justice (2008) there were over 30,000 requests per year to central government bodies alone and the majority came from members of the general public (Brown, 2009). An analysis of news stories in 2006 and 2007 revealed over 1,000 stories were based on results from FOI disclosures (Campaign for Freedom, 2008 in Brown, 2009). Interestingly, many of these news stories were based on criminal justice issues, yet criminologists have been slow to utilise the act for criminal justice data or information relating to their own research. Brown (2009, p.89) points out that many universities 'offer training from a compliance perspective on how university staff should respond to FOI requests, but fail to provide any training on how academic researchers can use the tool to obtain information'. FOI is thus seen as something to protect against rather than a resource. This is evidenced by Wilson (2011) who has written about the ethics of universities providing data under the FOI Acts. Hazell, Bourke and Worthy (2012) published a guide for academic researchers on making FOI requests. This guide includes an overview of the governing legislation, how to make a request, some common errors to avoid in designing the request, how to manage the requests and appeals procedures.

It has been argued that social researchers use a relatively narrow range of data collection techniques (Lee, 2005) and the need to find innovative methods has been of increasing importance in social science and related disciplines. Despite the comparably widespread use of FOI in other jurisdictions,

social scientists, and criminologists in particular, have not utilised FOI requests. In respect of sexual violence, no studies were found that utilised FOI requests and researchers in other fields using this approach rarely discuss it in their methodological literature, with a few exceptions mainly emerging from medical and health disciplines (Murray, 2012; Farrukh and Mayberry, 2015; for a review see Fowler *et al*., 2013).

3.3.2 Sampling

Following an initial pilot with five forces to assess any issues flagged up in responses from the FOI departments, FOI requests were sent out to all 46 forces in the UK. The requests were based on two questionnaires (Appendix 2). The first questionnaire asked about: the number of recorded section one and section two forces between 1st January 2009 and 31st December 2013, broken down by year (i.e. 1st January 2009 to 31st December 2009) and offence type; and the proportion of those cases involving a victim aged 60 or over at the time of the offence, broken down by year and offence type). The second questionnaire asked for demographic data for each case involving a victim aged 60 or over at the time. The questionnaire asked for the following specific data: the type of offence and year it was reported; the gender of the victim and perpetrator; the age of the victim and perpetrator; the ethnicity of the victim and perpetrator; the relationship between the victim and perpetrator; the location of the offence; whether the crime was linked to any other crime; whether the perpetrator was a known serial offender. For the request data on the ages, relationship, location variables, pre-defined categories were provided, for example in the relationship variable, broad categories such as 'partner or husband/wife' and 'friend' were used. The inclusion criteria and guidance notes are provided in Appendix 1.

3.3.3 Data analysis

Although the data gained through FOI requests already exists and has been collected by individual forces during the incident recording process, the data is not publicly available or published in any existing reports or datasets. However, as has been pointed out by Savage and Hyde (2012, p.8) FOI requests fall outside the 'traditional dichotomy between primary and secondary research' and individual researchers differ in their view of whether the data collection is primary or secondary. In this study, as the data collected was not at the time available in the format it was collected and analysed, the collection of this data through FOI requests and the subsequent analysis were viewed as primary data analysis.

Quantitative data is often analysed using computer programmes such as SPSS, however there are other methods of analysing data, depending on the size and nature of the dataset. The primary aim of the analysis was to produce descriptive statistics which described the patterns of characteristics of victims, perpetrators and offences in the dataset. In this study, both Microsoft Excel and SPSS were used to analyse the data.

The dataset comprised 613 cases, within which there were ten variables relating to victim or offence demographics or characteristics (gender, ethnicity and age group of victims and perpetrators; relationship between victim and perpetrator; location of rape; whether the offender was a known serial offender; and whether the rape was linked to any other offence). These were inputted into an Excel spreadsheet which was subsequently inputted into SPSS. Data pertaining to each variable was coded and assigned to either nominal or ordinal data. Once all the data had been inputted,

frequencies were ran to see how many were in each variable then ran comparisons using cross tabulations on areas where this was possible.

3.3.4 Managing the requests

Forty-three forces provided some or all of the requested data, a response rate of 93 per cent. This is slightly higher than has been reported in other studies utilising FOI requests (Murray, 2012). One force (Scotland) did not comply on the basis of the size of their recently integrated size and their previous recording methods. Two forces did not comply with the FOI request, but follow up emails via personal contacts with senior officers resulted in the data being provided directly rather than via the FOI route. Therefore, the total response rate was 45 out of 46 forces (98 per cent).

The majority of forces (36) responded fully within 28-40 days of acknowledging receipt of the request. A small number of forces emailed asking for clarification on the terms used in the request. For example, two forces asked what was meant by the question 'was the rape (section 1 Sexual Offences Act 2003) or sexual assault by penetration (section 2 Sexual Offences Act 2003) linked to any other offence'. The forces stated they were unsure what was meant by 'any other offence' and asked for examples. On reflection, this question was quite vague, but was intended to examine whether other offences such as burglary, theft, or assault offences occurred at the same time as the sexual offence. This highlights the need to consider the terms used when drafting FOI requests and providing detail on what is meant by the question you are asking. A pilot of the request was initially carried out with three forces who helped to identify potential issues with the wording and format of the request, however issues such as the lack of clarity in this question still arose.

A number of forces initially exercised the right to refuse the request because it exceeded the time/cost allowed under section 12 of the Freedom of Information Act, however in these cases forces gave most of the data and left one or two variables out (for example, one force provided all of the data other than the 'relationship between victim and perpetrator' variable). In some cases, further discussions with the FOI team led to the information being released; this exemption is 'non-absolute' and as a result the force are required to apply the public interest test. Through discussions with the individual forces about the need for this research and, on some occasions, promising to provide them with an overview of the findings, access was granted. However, a very small number of forces initially refused to provide the data altogether, or provided only the total number of recorded offences and the proportion involving a victim aged 60 or over. For those refusing, the reasons were usually based on the section 12 (cost/time) exemption or section 40 (identifying an individual). For example, one force had only received one report of rape involving a victim aged 60 or over and thus providing information on the victim and perpetrator age, relationship, ethnicity and so on may have compromised the anonymity of the victim.

For those refusing on the section 12 grounds, these were challenged successfully by highlighting to forces the other, often larger, forces who had provided the data within the time/cost allowed under the act or by negotiating on how the data was presented. For example, some forces agreed to send the data of all the cases involving an older victim which meant I had to analyse the variables to draw out the relevant information, which saved the force the time of completing this task. Others asked to provide the data in more aggregated ways, for example giving the total number of victims in each age group, the total number under each relationship category and so on. This was particularly the case where victim or perpetrator's identity might be compromised by providing individual level data for each case. This is considered in more detail below.

One force (Scotland) could not provide the requested data because the previously independent Scottish forces had recently merged into a single, central force and the process of transferring all of the data from the various databases to a single database had not taken place. Thus, the information requested was not retrievable in the time allowed under the act.

One force completely refused to provide the individual data, based on the time/cost exemption, instead providing the overall number of recorded offences but no data on the variables requested. Due to the size of the force, which was considerably larger than the other forces who had refused, they stated they could not provide the data within 18 hours. Another force kept promising the data, but after six months had still not provided it despite numerous telephone calls and email exchanges with the FOI team. In both of these cases, the data was obtained by using existing connections and networks in the forces. This highlights the limitation of FOI in social research where the organisation can rely on the section 12 exemption, either because of the size of the data requested or the databases/methods of retrieving the information utilised by the organisation. This can lead to inconsistency, particularly in the police where there is no single database used by all forces and therefore a lack of consistency in relation to how feasible it is to obtain the information within the 18-hour timeframe. Moreover, this may be a particular challenge for early-career researchers who may not have existing contacts or networks they can rely on to get the data outside of the FOI request.

3.3.5 Negotiating with Freedom of Information Gatekeepers

Public authorities, in this case police forces, act as 'gatekeepers' to what is, prima facie, public information but which has not previously been published to the general public. Issues associated

with negotiating gatekeepers in research have been well documented. Gatekeepers are defined as 'individuals in an organisation who have the power to withhold access to people or situations for the purposes of research' (Sanghera and Thapar-Björkert, 2008, p.549). Most of the existing research discusses issues relating to gatekeepers in qualitative research, specifically in negotiating access to research participants who are often, particularly in feminist research, from marginalised groups (Fielding, 2001; Wiles *et al*., 2005; Heath *et al*., 2004; Sanghera and Thapar-Björkert, 2008). There is significantly less literature dealing with gatekeepers in quantitative research.

In the present study, FOI teams acted as gatekeepers to the data being requested. Whilst in the majority of cases the data was provided within the time allocated within the act and in full, a number of gatekeepers had to be negotiated with to provide access, particularly as the majority of refusals were based on the section 12 cost/time exemption which is non-absolute, thus requiring the gatekeeper to assess whether the release of information is in the public interest. In this sense, the exemptions provided both a barrier and opportunity for the researcher. Whilst initially it was a barrier that some forces relied on to refuse the disclosure of the request, the built in public interest test allowed the researcher to discuss the need for the research and potential benefits, which in the majority of cases was enough to persuade the gatekeeper to release part, or all, of the data. However, this highlights the inconsistency in the way information is released under FOI requests and the limitations of the FOI which intended to remove the need to jump through hoops to gain access to public information.

3.3.6 Ethics and FOI requests

There are ethical considerations when using FOI as a methodological tool. Savage and Hyde (2012, p.8) highlight that freedom of information requests 'fall outside the traditional dichotomy between primary and secondary research, which is often used to identify the ethical issues that are raised by research'.

Although the information gleaned from FOI requests is publicly available, it is only made so because of a request by a researcher. As such, this feature of the FOI raises ethical concerns because of the similar features to interviews or surveys 'where data is generated due to the request of the researcher' (Savage and Hyde, 2012, p.8). The use of FOI, however, is not directly comparable with interview or survey methods in relation to the 'consent' element of the process; in the other methods, participants would be required to give free and informed consent to provide data through surveys or interviews. However, with FOIs, the public body is essentially compelled to give the data by virtue of the legislation. Consequently, consent cannot be said to be freely given by the forces participating in this research. However, the exemptions within the act do allow the forces to refuse to provide the data in some circumstances, thus the obligation is not absolute. Nevertheless, the issues of consent in FOI research has not yet been thoroughly considered in the existing literature.

There are two main ethical issues identified by Savage and Hyde (2012). First, the public authority supplying the information following a FOI request may fail to remove personal data which is therefore not compliant with the FOIA. The second potential issue is embedded data within a disclosed document which may identify the producer of the document.

Moreover, Walby and Larsen (2012) clarify that FOI disclosures do not provide access to 'pure' or complete data and warn that access is only ever partial, so our claims must always be qualified (p.39).

Therefore, it is possible that cases of rape or sexual assault by penetration have not been included in the data provided by forces because of the criteria used to request data from the forces and the lack of consistency between force databases. Furthermore, it may be that some case variables have not been recorded properly in individual cases, or identified correctly by the FOI officer, which means the information provided may not be accurate. However, the risk of these issues materialising was reduced by piloting the request with five forces before sending the request to the remaining 41 forces and resolving any issues identified in the pilot.

3.3.7 Using FOI requests as part of a mixed-method study

Although the use of FOI requests raises a number of potential methodological and ethical issues, it is a useful tool which provides researchers access to information not currently publicly available. For projects examining marginalised groups who may be difficult to recruit into qualitative studies, this is particularly useful. The use of FOI requests in this study was particularly beneficial as it helped inform the qualitative interviews which followed. The approach of combining quantitative and qualitative methods in feminist research has been encouraged by feminists (Oakley, 1999; Shapiro, Setterlund and Cragg, 2003) as they have the potential to give a more powerful voice to women's experiences (Hodgkin, 2008) and it increases the likelihood of researchers understanding what they are studying and their ability to persuade others of the credibility of the research (Reinharz and Davidman, 1992). Whilst there have been some concerns about the incompatibility of qualitative and quantitative paradigms (Bryman, 2006; Kidder and Fine, 1987) a sequential approach can overcome these issues because the data collection methods involve 'collecting data in an iterative process whereby the data collected in one phase contribute to data collected in the next' (Driscoll *et al*., 2007, p.21). This is

particularly useful where there are different methods used for different elements of the study and there is a multi-research rather than a mixed-methods approach.

3.3.8 Summary and limitations

Despite their accessibility, there are numerous complexities involved in using crime data for research, not least because crime is a complex and multifaceted phenomenon (Davies *et al*., 2011). Police recorded crimes are those offences that are known to the authorities and classified accordingly. However, there are many dimensions to crime not captured by police statistics. Furthermore, how one person experiences an incident may differ from how someone else and thus how they define it and report it (or not) (Davies *et al*., 2011).

Police statistics on recorded sexual offences are used as part of the annual report published by the Home Office which collates and compares this data with that collected and analysed by the CSEW. Together, both sources are used to provide an overall picture of sexual offending and victimisation in the UK (Smith, 2006). Smith (2006) notes the benefits of police recorded crime are that it has the advantage that it covers the full range of crimes and are the only data that can be used to look at crime at neighbourhood level. It has the disadvantage that it largely depends on the public reporting crimes to the police (CSEW data for 2011/12 suggests only 15% report sexual violence incidents to the police) and on the police recording all of the crimes reported to them. It can also be open to the suggestion that recording may be influenced by the demands of performance management regimes. Therefore, it is likely that a number of rapes have not been included in the data collected in this

research either because they have not been recorded by the police at all or have not been recorded as rapes.

Questions about the integrity of police recorded crime statistics have been regularly raised since they were introduced in 1857 and have been considered by the Home Office (for example, Smith 2006, discussed above) as well as independent academics who have analysed the data for the purposes of their study topic. Several researchers have highlighted the issues with police recorded rape and sexual offence data. For example, Lea *et al*. (2003) examined attrition in rape cases based on data from constabulary in the South West of England over a five-year period. They found that gaining basic statistics on the number of recorded incidents over that period was relatively straight forward, but inconsistencies in police recording of details associated with each case (i.e. demographic information and assault characteristics), missing and incomplete data made it difficult to extract data from the constabulary database and therefore questionnaires were developed based on a pro-forma and sent to the individual senior investigating officers in each of the cases and relied on the officer being able to accurately recall or locate the information requested. Although relatively successful (80 per cent return rate of the total sample of cases) there were nonetheless complications.

Therefore, the data gained in this study on the characteristics of victims and perpetrators may not fully reflect the range of characteristics, as with some variables large chunks of data were missing or not provided. In particular, the ethnicity of victims and perpetrators was not known or not provided in the majority of cases, therefore conclusions made about the ethnicity of victims and perpetrators based on the available data are limited. Similarly, there is significant missing data for the 'serial' and 'linked' variables.

Finally, the use of FOI is subject to a number of limitations, described in section 3.3.1, in particular the reliance on FOI officers to provide the data requested, which is always subject to a certain degree of interpretation by the officer responding to the request, which may mean the data collected is not complete.

3.4 Qualitative data collection

Phase two and three of the research involved qualitative interviews. Phase two involved interviews with 23 practitioners working in sexual violence or domestic violence roles and four interviews with practitioners working in age-related organisations. Phase three involved interviews with three female survivors of sexual violence who had been raped since the age of 60.

Qualitative interviews are a particularly useful method when interviewing practitioners working with sexual violence survivors, as it allows the researcher to gather rich and in-depth information about the practices within organisations as well as the issues and challenges practitioners face (Campbell, 1998). Moreover, as Ullman and Townsend (2007) observe, practitioners working at sexual violence organisations are a useful source of information in a number of ways. First, they can help identify the barriers victims face in a number of contexts, for example reporting assault to criminal justice agencies, or accessing support. Second, advocates may also be important sources of information about the challenges service providers face when assisting survivors, for example vicarious trauma and other physical or psychological impacts as a result of working in these roles (Baird and Jenkins, 2003; Ghahramanlou and Brodbeck, 2000; Schauben and Frazier, 1995). Third, understanding the perspectives of service providers on service-related barriers can help researchers who are attempting to do collaborative research on sexual violence. This was particularly relevant in this study, which sought to examine the barriers from the viewpoint of both service providers and service users with a

view to informing future policy and practice in sexual violence organisations. Although not directly a collaborative study, the research received national support from rape crisis as well as local individual centres who promoted the research through a number of mediums (for example social networking, the e-bulletin and the national annual conference).

As discussed earlier in this book, feminists have used an array of research methods, depending on the topic and context of the topic, unstructured or semi-structured interviews have been a key method in exploring the experiences of women who have been raped or sexually assaulted (Skinner *et al*., 2005; Oakley, 1981; Westmarland, 2001). Feminist researchers, greatly influenced by the work of Ann Oakley, make every effort to conduct interviews in a way that does not further oppress the participant (Westmarland, 2001). Feminists have been critical of the use of interviewing practices that employ unidirectional methods, based on a hierarchical relationship between the researcher and participant (Sarantakos, 2012). In-depth interviews have been seen as a better option because they encourage subjectivity and open dialogue between the researcher and participant. As such, interviews are a useful method for examining practitioner views as well as survivor experiences.

Corbin and Morse (2003) identify several types of interviews. There are unstructured interactive interviews, semi-structured interviews, and structured interviews, the main difference between them being the degree to which participants have control over the process and content of the interview (Fontana and Frey, 1998; Morse, 2002). In line with other feminist research epistemology, such as Oakley (1981) who suggests that the research interviewer should take an active role in the development of data rather than acting as merely an 'instrument of data collection' (p.48) the approach taken in this research focused on conversation between the interviewer and the interviewee using semi-structured interviews. Whilst structured interviews usually consist of closed

questions with an exhaustive list of potential responses, and unstructured interviews have far fewer questions, which are open and focus on 'figuring out what events mean, how people adapt, and how they view what has happened to them and around them' (Rubin and Rubin, 1995, p.34-35) in semi-structured interviews the main questions are decided in advance of the interview 'but interviewers are able to improvise with follow-up questions and to explore meanings and areas of interest that emerge' (Arksey and Knight, 1999, p.7). Semi-structured interviews were chosen for this study for interviewing both practitioners and survivors. In order to address the research aims and objectives, this was deemed the most appropriate style of interview as it allowed for a set of loose questions to be used, which guided the interview but allowed for flexibility in the data provided by participants and further probes on answers they provided.

Plummer (1995) suggests stories disclosed in interviews are joint actions, with one actor taking the role of storyteller and the other actor as a coaxer who encourages the storyteller to tell things they have not spoken about before. Grenz (2010) argues that one must therefore consider the:

> 'interactive character of storytelling in any research project and keep in mind the fact that participants alter their stories according to: a) what they think the interviewer expects to or can bear to hear; b) how they believe s/he is going to interpret what is said; and c) how what is said will be perceived by the wider public when the study is published' (p.57).

One of the benefits of adopting a semi-structured approach is that it allows the interviewee to have some control over the information given and can reduce the chance of interviewees giving responses they feel the researcher expects. With this in mind, interview schedules were developed around open questions, allowing participants to shape the interview and have control over the information

given, with a view to reducing the extent to which participants might provide answers they feel the researcher wants to hear.

3.4.1 Sampling

Professionals from rape and sexual violence support organisations and those working at age-related services were approached through a range of mediums. A purposive, snowball sampling technique was utilised to recruit professionals. Purposive sampling is often used when small samples are studied using intense, focused methods such as in-depth interviews (Curtis *et al*., 2000). As Atkinson and Flint (2004, p.1044) explain, snowball sampling:

> 'can be placed within a wider set of methodologies that takes advantage of the social networks of identified respondents, which can be used to provide a researcher with an escalating set of potential contacts.'

After the initial participant helps to recruit further respondents, those respondents then recruit others themselves starting a process analogous to a snowball rolling down a hill (Everitt and Howell, 2005).

The research was promoted through a number of mediums. First, all rape crisis centres, SARCs and domestic violence refuges were emailed with a copy of the information sheet and invited to participate. Second, information was included twice in the e-bulletin which is sent to all rape crisis centres on a frequent basis[3]. Third, the information sheet was included in the 2014 rape crisis annual

[3] This ranges from every four to six weeks

conference delegate bags. The conference is well attended by practitioners working in centres across England and Wales. Scotland rape crisis also put information about the study on their website. Finally, social media, in particular twitter, was used to promote the research and invite practitioners to participate. All practitioners who responded to these mediums and agreed to take part in the research were asked to circulate to their relevant colleagues or contacts and/or to provide the details of people who met the criteria who they thought may be interested and willing to participate, hence the snowball sample developed.

A total of 23 practitioners working in rape crisis, sexual assault referral centres or domestic violence services across England were interviewed. Most of the practitioners were recruited through the email invitations sent to the services. One practitioner got in touch following the conference in 2014 where she had picked up an information sheet in her conference pack. Five practitioners responded to messages on Twitter calling for participants. Participants were all given information sheets and consent forms in advance of interviews, both of which explained the purpose of the study and what would be expected of them if they participated. It was made clear to practitioners that taking part in the study was voluntary and there was no obligation to agree to interviews, and consent could be withdrawn at any point during the research until the hand-in date in September 2016. It was also stressed from the outset that any information provided about individual cases would be anonymised, and practitioners' names would also not be given in the report; instead, they would be referred to by their broad job title.

Originally, it was anticipated that the research would also include a similar number of interviews with practitioners working at age-related organisations. However, when approaching local and national age-related organisations such as Age UK and Action on Elder Abuse it became apparent that

practitioners in these organisations had very limited experience with older people disclosing sexual violence. For example, the national Age UK Helpline had only recorded one phone call from an older person disclosing sexual violence and were of the opinion that this disclosure was unlikely to be legitimate[4]. This is concerning, not only that the number is so small, but that the assumption from staff was that this disclosure was probably false. Further details on why this might be 'false' were not provided. The national Action on Elder Abuse (AEA) helpline analysed their records from between 2009 and 2013 and found 0.42 per cent of calls included a disclosure of sexual violence (equating to 70-80 calls per year)[5] however this includes recent and 'historic' experiences (typically occurring in childhood or early adulthood) and further data on the number exclusively involving recent experiences (those that had occurred in later life) were not available. At a local level, the age-related organisations approached to take part in the research expressed concern that they could not contribute meaningfully because of a lack of experience in this area. Therefore, a total sample of four age-related practitioners were interviewed about their perceptions of the reasons for the low numbers of older people disclosing sexual violence and what the challenges or barriers might be. These four practitioners were recruited through convenience sampling (using existing contacts) and through email invitations to national age-related organisations.

Gaining access to older survivors of sexual violence was problematic. At the proposal stage of this research, a guide number of 10 interviews with older survivors was suggested, who would be accessed through practitioners interviewed in Phase Two of the research. However, it became apparent very early on in the study that practitioners in sexual violence organisations had very limited experience of supporting people aged 60 and over who were accessing support services for recent

[4] Personal email communication with Age UK
[5] Personal email and telephone communication with Action on Elder Abuse

sexual violence; the vast majority of older people accessing these services are disclosing previous sexual violence in earlier life, often childhood or early adulthood (typically referred to as 'historic abuse'). A number of alternative approaches were attempted, including promoting the research through Age UK on their national website, using Gransnet.com, a website and forum dedicated to older people, to promote the research through a specific 'thread' and using social media, in particular Twitter, to circulate information about the study around old age related organisations (including Age UK and Action on Elder Abuse). None of these methods were successful. However, this is not surprising, as other researchers have reported similar experiences; Roger *et al*. (2015) admit that the recruitment of older survivors can be challenging, resulting in lower numbers of people who come forward than is commonly believed to be the reality of abuse. They argue:

> The task of recruiting today's older adults to talk about abuse, a uniquely vulnerable population due to factors related to age, and a group who has been well trained not to discuss private family matters outside of the family, remains an elusive reality positioning research on this topic on a precarious edge, looking like a non-issue. (2015, p.366)

Through the interviews conducted with practitioners, three survivors of older female sexual violence were recruited. Practitioners were asked to identify older survivors who were currently, or had recently, engaged with the service and who might be interested in participating the research. None of the practitioners were supporting any male victims at the time of the study and, despite the efforts described above to recruit both men and women (through Gransnets and other platforms) no men came forward. Information sheets (Appendix 4) for survivor participants were provided via practitioners. The only criteria for participation was that the survivor had experienced at least one form of sexual violence since the age of 60. No specific definition of sexual violence was provided, as

people have differing definitions and view different behaviours as sexually violent, and it was important not to invalidate those experiences.

Although the overall sample was lower than originally anticipated and this was disappointing, this study does nevertheless fill a gap in the existing research in this area, as only one published study to date has included interviews with older survivors; Scriver *et al*. (2013) included two interviews with older women, one who experienced childhood sexual violence and one who had experienced sexual violence in older age. It may be that the lack of previous research including interviews with older people is telling of the challenges in recruiting older survivors as research participants.

3.4.2 Interviews with practitioners

Policy has generally been developed from a top-down approach focusing on criminal actions and the responsibilities of investigating agencies rather than on the perceptions and needs of older people (Estes, 2001; Philips, 1986 in O'Brien *et al*., 2011). With that in mind, the focus of the interviews was to collect data from both practitioners working in support capacities in both age-related organisations and sexual violence support services and older female survivors of sexual violence, to develop rich data from the 'bottom up' on the needs of older sexual violence survivors and the perceptions of these needs held by relevant organisations.

An interview schedule was developed to be used for all 27 practitioners, however it became apparent that the schedule used with sexual violence practitioners (SVP) would need to be altered for age-related practitioners (ARP), as none of the ARPs had any direct experience of supporting older survivors of sexual violence. The interviews with practitioners focused on exploring the support

offered to older sexual violence survivors by the sexual violence organisations participating in the study and whether the professionals working in these organisations feel these services are adequate and suitable to support older women. The schedule was semi-structured in that it had guiding questions, but was left deliberately broad to let each individual organisation shape the discussion and provide the answers as appropriate for their particular services. The questions were guided by the overreaching research objectives and sought to examine:

- The extent of experience practitioners had of supporting older survivors
- Practitioner perceptions of the effects and impacts of sexual violence on older people
- Practitioner perceptions and opinions of challenges older people face and how age affects their experiences
- The key support needs of older survivors who had accessed practitioner's organisations and whether these differ from younger survivors, and the extent to which services feel competent to meet these needs
- Perceptions of the current gaps in service provision

The interview schedule used with ARPs similarly focused on the perceptions of practitioners about the barriers or challenges older people may face in accessing support or disclosing sexual violence, the reasons why so few had contacted age-related organisations, the confidence practitioners felt (including what training they received) in supporting older survivors of sexual violence and their opinions on what should be developed for older survivors. Again, the interview schedule was semi-structured, allowing for participants to shape the direction of the interview and the information provided, which was particularly important as ARPs were providing perceptions based on their

experiences of working with older people generally, rather than direct experiences of working with older survivors.

3.4.3 Interviews with women survivors

Interviews were conducted with three women survivors who had experienced sexual violence since the age of 60. All three had experienced rape. The women lived in three different geographical areas of England. One interview took place at the premises of the support agency through which the woman was currently accessing support. This interview was conducted by the support worker at the organisation and was audio recorded and then sent via email. The survivor had requested the support worker conduct the interview as she felt more comfortable with this. Moreover, the woman had mild learning difficulties and as the support worker had built a relationship with her, it was more appropriate for the support worker to conduct the interview. One interview was conducted at the survivor's home; a flat within a residential living block. The third interview was conducted in a holiday caravan at a caravan park where the survivor and her friend were holidaying.

A loose interview schedule was designed (Appendix 3) and was developed using examples adopted in previous qualitative research with rape survivors (Campbell *et al*., 2011) and research involving older people (Wenger, 2002; Minocha *et al*., 2013). The schedule was intentionally broad with quite general open questions allowing for participants to shape the direction of the interview but had probes and discussion points to give the interview some direction and to ensure the relevant information was collected in order to address the research objectives. In-depth unstructured or semi-structured interviews 'offer researchers access to people's ideas, thoughts and memories in their own words, rather than the words of the researcher' (Reinharz and Davidman, 1992, p.19).

Minocha *et al*. (2013) suggest that older women in particular may prefer an open conversation approach opposed to structured interview methods and this underpinned the schedule. With this in mind, and to build rapport, the interviews began with 'small talk'; the first section asked the survivor about themselves, whether they had lived in the local area for a long time, whether they had children/grandchildren before moving on to ask them how they had come to be involved in the support service through which they had been contacted and invited to participate in the research.

The remaining interview questions were centred on their experiences, in particular the impacts of sexual violence on their life and challenges they faced reporting or accessing support services, and whether age affected these experiences. Koss (1993) suggests two key strategies for facilitating disclosure of violence in the research interview. First, giving the participant multiple opportunities to disclose her experiences throughout the interview, allowing the woman time to think about her experiences and to build up enough trust to make the disclosure. The second strategy is using specific questions about behaviours rather than asking general, subjective questions such as 'have you ever been abused?'. The former approach was taken, asking quite broad questions about how the woman had come into contact with the support service she had been recruited through, how long she had been engaging with the counsellor or support practitioner and so on, until the woman felt comfortable providing detail about the rape. No questions asking the woman to directly discuss the rape were asked.

Whilst there are some specific considerations in conducting research with older women, it is important not to homogenise older women and assume they will have difficulties that younger people would not. As others have pointed out, it is important that those who interview older women

try not to become preoccupied with age; they should not assume that everything under consideration is age related (Duffy, 1988). Some of the specific methodological considerations relevant to this study are discussed in 3.4.5.

All three survivors were provided with an information sheet about the study and a consent form which they signed. Two of the survivors were spoken to about the research by telephone prior to the interviews and the survivor who was interviewed by her support worker was provided with information about the study through discussions with the support worker prior to the interview. The purpose of the study was explained at the beginning of the interview and survivors were invited to ask questions or stop the interview for a break at any time during the interview. They were also informed that they could withdraw from the study at any point. Participants chose a pseudonym and any identifying information about them or third parties were removed from the transcripts.

Interviews lasted between an hour and three hours, which was led and ultimately determined by participants who were be given as much time as they wished to talk about their experiences and perspectives (Campbell *et al*., 2011). One of the key concerns of feminist research is the power relationship between the researcher and the researched, often referred to as a 'hierarchy' in qualitative interviews. Feminists in sociology initiated the discussion on power relationships in women interviewing women in the 1980s and called for a non-hierarchal relationship (Tang, 2002). Oakley (1988) was one of the pioneers in encouraging feminist researchers to reduce the hierarchy by giving more control to participants. For Oakley and others (Stanley and Wise, 1990; Maynard, 1994) this is important to ensure participants are not simply 'used' for the research purposes and that participating in research empowers participants (DeVault and Gross, 2007; Hollway and Jefferson, 2008).

With this is mind, I willingly answered questions asked by participants about my own life and experiences, and offered information about myself throughout the interview. Prior to interviews commencing with survivors, I built rapport with general chit-chat and shared information about myself. For example, one participant noted my accent was not local and asked about where I was from. These initial conversations helped to establish the open dialogue that continued through the interviews.

3.4.4 Analysis of interview data

The majority of interviews with practitioners were conducted by telephone and were typed verbatim during the interview (with permission of the practitioner) as practitioners were geographically spread across England and it was not possible to travel to every location. This process was enabled by earlier training as a legal secretary. This technique was adopted as it was difficult to record telephone interviews due to a lack of appropriate software and the unreliability of the quality of using Dictaphones or smart phones to record telephone conversations.

However, a number of face-to-face interviews were carried out with more local practitioners and these were audio recorded (with prior permission of the practitioner) and transcribed. Jones (1985) and Kelly (1985) suggest that researchers should listen to taped interviews at least twice (cited in McNulty, 2012). The first 'hearing' provides an overview of the entire interview: its tone, mood, and dynamics. A second 'hearing' allows for the data to be scrutinised in more detail (McNulty, 2012). Therefore, audio-recordings were listened to twice, the first time involved transcribing the recording and making any additional notes on the mood and dynamics of the interview; the second time

involved checking the transcript for accuracy and making any required amendments. In addition, written notes made during the interview were considered alongside the transcriptions. Once transcribed the audio-recordings were destroyed.

The total number of practitioner interviews (n=27) allowed for a grounded thematic analysis. A grounded theory approach, a type of thematic coding, was adopted to analyse the data, focusing on capturing what participants said. Grounded theory is broadly defined as general methodology for developing theory that is grounded in the data, which is then analysed in a systematic fashion (Allen, 2011). Constructivist grounded theory develops on these key principles but uses them as guidelines rather than subscribing to the objectivist and positivist assumptions (Charmaz, 2006) inherent in the traditional grounded theory. Constructivist grounded theory is particularly well suited to the feminist intersectional framework of this study as it:

> 'assumes to relativeness of multiple social realities, recognises the mutual creation of knowledge by the viewer and viewed, and aims towards interpretive understandings of subjective meanings' (p.250).

Coding began by reading over the transcripts and attaching a descriptive 'label' to each sentence which explained what was going on in the text. This then developed into labels which applied to larger chunks of text, for example paragraphs, and which provided a deeper level of understanding that the descriptive labels originally applied, seeking interpretation of the meaning of the data. Key themes were then drawn out of the data. This happened continuously throughout the data collection and analysis, and once the themes became saturated, they were copied and pasted in a document under each interview question to facilitate the write-up of the analysis in order to fully answer the

research aim and questions. However, these were constantly reviewed as more data were collected and analysed and additional codes and themes developed as they arose. For example, in response to a question about what challenges older survivors may face in accessing practitioner support services, all 23 sexual violence practitioners described different physical challenges such as reduced or restricted mobility, sight or hearing problems. Any challenges relating to physical issues, poor health or other conditions were therefore coded and grouped under the theme of 'physical challenges'.

Interviews with survivors were conducted face-to-face and were audio-recorded with permission of the survivor. As mentioned previously, one of the survivor interviews was conducted by her support worker. This was also audio-recorded and the audio file emailed to me. All audio recordings were transcribed and a pseudonym was assigned to the transcription file; audio recordings were then destroyed. Recordings were listened to twice, as per the suggested approach by Jones (1985) and Kelly (1985).

As the number of survivor participants was small, a case-study approach was considered the most appropriate way of analysing and writing up the findings from the interviews. A case study approach has no official definition but generally refers to a qualitative method, often using interviews, where the number of 'cases' is small and the amount of information or detail collected is large (Gomm, Hammersley and Foster, 2000). As such, transcripts were not formally coded; instead, each transcript was read a number of times and the data was separated into sections relating to: contextual information (for example, the participant's personal information, backgrounds and any details about the sexual violence); impacts of sexual violence; coping strategies; experiences of reporting or engaging with services; experiences of the criminal justice system; and gaps in support. Each case study has been written up in this structure and, whilst there are some similarities across the three

case studies, the aim is not to generalise or make connections by theme. Instead, the stories of the survivors are presented in this thesis and a discussion of some of the common issues, challenges or impacts across the three interviews are discussed where relevant. However, the aim of the analysis was not to combine the findings, but to present them as individual experiences. As Gomm, Hammersley and Foster (2000, p.4) explain, the main concern of the case study approach is usually with understanding the case studied in itself 'however the wider relevance of the findings may be conceptualised in terms of the provision of vicarious experience as a basis for 'naturalistic generalisation'. Delmar (2010, p.117) describes this as:

> 'the transfer of results from one study for the interpretation of similar situations. To achieve this, it is necessary to apply not only explicit comparisons between situations but also 'tacit knowledge' based on personal experience'.

Given the emphasis on the interpretation of the data, an Interpretative Phenomenological Analysis (IPA) framework was adopted to analyse these case studies, drawing on Smith (2004) and Jeffrey and Barata (2016). As Jeffrey and Barata (2016, p.6) explain:

> 'IPA aims to explore detailed perceptions or accounts of personal lived experiences, while recognizing and emphasizing the active role of interpretation by both participant and researcher in making sense of those personal accounts'.

As Smith (2004, p.40) explains, IPA can be described as double hermeneutic:

> ‘The participant is trying to make sense of their personal and social world; the researcher is trying to make sense of the participant trying to make sense of their personal and social world’.

It aims to say something in detail about the experiences of a particular group rather than to make general claims. Although primarily an approach associated with psychology, it can be applied to other social research where the focus is on individual experience and the way these are described and constructed. For feminists examining violence in the lives of marginalised groups, this is particularly applicable and aligns with the case study approach. The experiences of the three women interviewed were given the central focus and their words used to reflect their experiences, but interpretation of those experiences through close analysis of those words then followed, paying particular attention to gender and age, reflecting the feminist-gerontological theoretical approach guiding the research. In keeping with the central tenets of IPA, and following the model used by Jeffrey and Barata (2016, p.6), the critical analysis came after the empathic reading of the text and is therefore incorporated into the discussion section, ‘allowing the analysis section to remain closely grounded in participants’ words’. Jeffrey and Barata (2016, p.6) suggest that:

> ‘combining these two levels of interpretation allowed us to simultaneously capture the embodied, phenomenological meaning of the text and hidden meaning through the use of language, including the reproduction of oppressive discourses and ways in which experience is constrained by gendered power relations’.

3.4.5 Methodological considerations

There is a growing recognition that undertaking qualitative research can pose many challenges for researchers (Dickson-Swift *et al*., 2007). In particular, there are a number of methodological and ethical considerations when conducting research on 'sensitive topics' such as sexual violence, with 'vulnerable populations' including survivors of violence and 'older people' (Dickson-Swift *et al*., 2007).

Phase three of this doctoral research involved interviews with older women about their experiences and the impacts of experiencing sexual violence in their later years. As such, this research clearly fits within the definitions of sensitive topics and vulnerable populations. Some of the methodological challenges associated with this type of qualitative research have already been discussed, including recruiting and sampling. However, literature from the health and gerontology fields suggest that qualitative research involving interviews with older populations may pose additional methodological challenges (Stöckl *et al*., 2012; Wenger, 2002; Minocha *et al*., 2013).

One of the first challenges is disclosing and describing the violence and its impacts to a researcher, particularly one who is likely to be much younger than the participant (Hagemann-White, 2001; Stöckl *et al.*, 2012). One of the interviews was conducted by a support worker who knew the survivor and was nearer in age to the survivor, the other two interviews I conducted. There was a minimum of 34 years age difference between the researcher and survivor. Reflections on this process are provided at the end of this chapter.

Ellsberg *et al*. (2001) argue that painful subjects such as violence create challenges around convincing people to speak openly about their intimate lives and experiences. They argue that the degree to

which openness is achieved depends partly on the design of research methods, such as how questions are worded and how many times in an interview a woman is asked about violence. Furthermore, how comfortable women feel during the interview will influence disclosure. The level of comfort can be affected by many factors including the gender of the interviewer, interview length, the presence of other people, and whether the interviewer appears to be genuinely interested in the participant's story and is willing to listen without making judgement. Survivors were given as long as they wanted to describe their experiences and answer questions, and the conversations were reciprocal to aid rapport and create a more relaxed environment. Moreover, survivors were given the option of where the interview take place and two chose a home/holiday location where they were most comfortable.

Several researchers have suggested the research process can be very tiring for some older women, particularly interviews which require the participant to talk about specific events in detail, some of which may have occurred some time ago (Minocha *et al*., 2013; Stöckl *et al*., 2012). The interviews lasted between one and three hours. In one of the interviews (conducted by the support worker) the survivor became tired and the decision was taken to stop the interview at that point and continue it the week after. In the other two interviews the women were told they could have a break whenever they wanted and the body language of survivors was continuously assessed to determine whether additional breaks should be offered. However, a break was not needed in either of these interviews.

A third issue identified in the existing literature is anxiety, particularly in relation to what the interview process will involve, what will be asked of participants and whether their contribution will be worthwhile (Stöckl *et al*., 2012; Wenger, 2002; Minocha *et al*., 2013). Minocha *et al*. (2013) observed that older women like to be prepared before an interview session as not knowing what is going to be

asked may raise anxiety. They describe the experience as being a 'black box' for some participants. Similarly, many older women who are unfamiliar with the research process may have anxieties around their contribution to the research. For example, Minocha *et al*. (2013) reflects on one particular incidence where an older woman asked whether she had 'done well' (p.6). This research mitigated any anxieties by fully informing participants of what was expected of them in the research process, including providing the questions in advance and explaining how the contributions would be used.

Wenger (2002) suggests that, among the practical challenges that researchers may encounter in interviewing older people, impaired hearing is one of the most common. Poor hearing may make an older person less willing to be interviewed. Similarly, impaired vision can reduce an older person's willingness to let anyone into the house, although it does not interfere with the comprehension of questions. Simple alterations can be made to the interview to combat these issues, for example speaking slowly and clearly, and repeating the questions where necessary. However, in this study, the survivors did not require additional help or measures during the interview, highlighting the importance of not assuming older people will suffer particular challenges or difficulties just because of their age.

3.5 Ethical considerations

The potential effects of qualitative research interviews on participants is a priority among scholars of research methods (Gatrell, 2009). Qualitative researchers are exhorted to prioritise the interests of the researched above the desire to collect data and achieve publications (Gatrell, 2009, p.111). There are ethical difficulties in conducting research directly with victims of sexual violence. Rape is a

distressing experience and researchers need to be careful not to increase or exacerbate the victim's stress (Brown *et al*., 2007). As Gatrell (2009) points out, the potentially exploitative nature of research interviews, in particular those which require participants to draw upon personal issues, remains a serious concern (p.111). Watts (2006) suggests the main ethical issues within the research process are to do no harm, do good and the recognition of autonomy on the part of participants. As such, three guiding ethical principles can be identified: consent; confidentiality; and conduct of research. These principles must be weighed against the balance of doing good and doing no harm.

3.5.1 Consent

According to the British Society of Criminology (BSC) research ethics guidance, all research should be based on the freely given informed consent of those studied. Although informed consent has no official definition, the BSC suggest it 'implies a responsibility on the part of the researchers to explain, as fully as possible, and in terms meaningful to the participants, what the research is about, who is undertaking and financing it, why it is being undertaken and how any research findings are to be disseminated' (2006, p.3). Some research has suggested people can be coerced into giving consent, fearing they will be letting people down if they do not partake, or that the services or support they currently receive will be removed or reduced if they refuse to participate (Fontes, 2004).

A consent form was drafted up (Appendix 5) and approved by Durham University Ethics Board (Appendix 6) and was given to participants at the same time as the information sheet, when the prospective participant is initially approached about participating in the study. Together, both the consent form and information sheet outlined the purpose of the study, what participating in the study would involve and what would be done with the material collected during interviews. It explicitly

stated that the study was entirely independent of the services through which older survivors were receiving support and that participating or not participating in the study would have no effect on their involvement with the agency or the support they are receiving. Any questions raised were referred back to the researcher and answered promptly. For example, some practitioners said they had very limited experience working with older people and wanted confirmation that their opinions would still be relevant for the study.

A copy of the consent form was provided to participants before the interview commenced for them to sign and an approach of 'active' consent was used, whereby information is adapted to meet their understanding. Where necessary, the form was also read aloud to participants. For example, the support worker for the third survivor (Mary) thought some of the questions in the interview schedule may pose some difficulties for Mary who had mild learning disabilities, so these were worded slightly differently to ensure Mary could understand them. Mary was given the questions in advance of the interview, which her support worker read to her, to check she understood them and was happy to participate. Although she had some learning difficulties, these were mild and her support worker felt these did not affect Mary's capacity to consent.

At this stage, any questions were answered and participants were again informed that they could withdraw their consent to contribute at any point without repercussions.

3.5.2 Confidentiality

One of the principle concerns of researchers conducting qualitative research interviews are the possible risks posed to confidentiality. The possible consequences can be of a social, financial, legal

or political nature (Corbin and Morse, 2003) and are of particular concern in researching sexual violence. However, as Corbin and Morse point out, a break in confidentiality is always possible when persons tell their secrets, even to friends and relatives, and is less likely to happen in the research interview. In the research situation, the risk of breaking confidentiality can be minimised through scrupulous attention to record handling and the concealing of identifying information (Larossa *et al*., 1981 cited in Corbin and Morse, 2003, p.336).

Practitioners are referred to in this study by their broad job title, and no identifying information about the organisation they work for is presented in the findings. Survivor participants were asked to choose a pseudonym and all potentially identifying information, such as their geographical location or that of the support service they are engaging with, and any information about the perpetrator or other family members has been anonymised. Survivors interviews, and some practitioner interviews, were audio recorded (with prior consent of the participant) and/or written notes taken. Audio recordings and written notes were transcribed and the originals were destroyed. Once the transcripts had been coded and analysed, these were also destroyed.

3.5.3 Conduct of research

The conduct of research principle is concerned with doing no harm and striving to do good. Gatrell (2009) notes that, despite the different philosophical positions underpinning qualitative research, the need to balance the interest of the research with responsibility towards participants has been foregrounded (p.112). Hollway and Jefferson (2000) describe the potential of research to exploit

participants. For feminists, this principle is based on the commitment to the participant's safety and minimising distress and trauma as a result of participating in research interviews.

A key concern for trauma researchers has been whether, and to what extent, victims of violence become upset or distressed by participating in interview research (Campbell *et al*., 2011). Feminist researchers have argued that, in carrying out research with vulnerable people, there is a need to be ethically responsible for the lives and well-being of participants and ensure they are not made more vulnerable (Lee, 1993; Flaskerud and Winslow, 1998 cited in Dickson-Swift *et al*., 2007). Fontes (2004) argues that the potential for re-traumatisation looms large in concerns about research into violence against women; the research itself may be traumatic as it reawakens memories of prior traumas.

Survivors in this research were accessed through the support services they are engaging with to ensure there was support available should they find the interview distressing or upsetting. Participants were told at the start of the interview that they were under no obligation to continue with the interview and could stop the interview at any point. If survivors did become upset or appear uncomfortable, the researcher offered them to take a break or stop the interview. However, it is important to remember that some degree of upset is not atypical because the research reminds people of their past victimisation experiences Campbell *et al*., 2011), but research has shown, overall that most participants do not describe research as unexpectedly upsetting (Newman and Kaloupek, 2004 in Campbell *et al*., 2011). Where women have been asked to reflect on their participation in research, what they tend to regard positively is a research process in which they are able to 'tell their story' and/or explore experience through the lens of the interview focus and questions (Downes *et al*., 2014).

In addition to ensuring participant safety, feminist methodology is also concerned with ensuring the researcher is safe. In research concerning violence against women there is often a concern about the physical safety of researchers who may conduct research at premises where an abusive partner may live or have access to. Interviews with practitioners took place at the premises of the service they worked for (whether face-to-face or over the telephone), with the exception of one interview which took place at the participant's home. One of the survivor interviews took place at the victim's home, which was part of a residential complex for older people, and the second survivor interview took place in a caravan at a holiday park where she was on holiday with a (female) friend. In both cases, the woman had no contact with the perpetrators at the time of the interview and had not for some time, so the risk to the researcher was small. The third interview was conducted by a support worker with the survivor at the premises of the support service therefore there was no risk to the researcher.

A more likely concern is the emotional safety and wellbeing of the researcher, particularly in rape research. Ellsberg *et al*. (2001) argue that listening to women's stories and experiences of violence can be distressing for researchers, some of who may find it difficult to conduct the research interviews. Support from formal and informal networks helped to minimise this. In addition, regular supervision meetings provided an opportunity to discuss any issues that had arisen during the research process or interviews. Reflections on the impacts of conducting this research are provided in the next section.

3.6 Reflections on conducting research with older women as a young woman

Reflexivity has gained a vital role in qualitative research (Hsiung, 2008, p.211) and is 'one of the fundamental concepts and practices that differentiate qualitative from quantitative research' (p.211). Reflexivity in qualitative research is increasingly seen as a fundamental resource for understanding data (Elliot *et al*., 2012) and is one of the main themes in discussions of feminist research Mauthner and Doucet (2003). Reflexivity requires the investigator to pay close attention to not only what respondents have to say but also where, when and under what circumstances they say it (Downing *et al*., 2013). Mauthner and Doucet (2003, p.418) note that, within discussions of reflexivity, 'attention is often drawn to the importance of recognising the social location of the researcher as well as the ways in which our emotional responses to respondents can shape our interpretation of their accounts.'

Whilst reflexivity is not exclusive to feminist researchers, it has been emphasised and brought to the fore in their writing (Sampson *et al*., 2008). Pillow (2003) points out that feminist theory and feminist researchers have 'furthered discussions of reflexivity by situating reflexivity as primary to feminist research and methodology' (p.178).

In this section, I offer reflections on researching sexual violence against older women as a younger woman (an 'outsider') and the emotional impacts of hearing the stories through qualitative interviews with older women survivors.

3.6.1 Being an outsider

Researcher positionality has been conceptualised in the social sciences as a central component in the process of data collection, particularly in relation to qualitative research (Ganga and Scott, 2006) and feminist researchers in particular, who regularly raise questions about the positioning of the researcher and the researched (Acker, 2000; Stanley and Wise, 1983, 1990; Cook and Fonow, 1990; Reinharz and Davidman, 1992; Harding, 1993). Consequently, qualitative researchers have engaged in extensive debates about the benefits and drawbacks of researchers being 'insiders' or 'outsiders' to the community they study (Kerstetter, 2012).

A number of benefits to being an 'insider' researcher have been identified, including the ability to engage research participants more easily and use their shared experiences to gather a richer set of data (Dwyer and Buckle, 2009). On the other hand, it has been suggested that they may find it difficult to separate their personal experiences from those of research participants (Kanuha, 2000), and face issues of confidentiality when interviewing members of their community about sensitive subjects (Serrant-Green, 2002, citing Kaufman, 1994). Conversely, outsider researchers are frequently valued for their objectivity and emotional distance from a situation, but may find it difficult to gain access to research participants (Chawla-Duggan, 2007; Gasman and Payton-Stewart, 2006). However, several researchers have reflected on their methodological choices and the impacts of being an 'outsider', that is, researching a group that you do not belong to because of age and class, gender, ethnicity, life experiences or some other reason (Ganga and Scott, 2006).

Although I shared some commonalities with the survivors I was interviewing, primarily gender, and in some cases class, the main difference was age; the women I interviewed were at least 34 years older than me. Furthermore, I do not share their experiences of sexual violence. I was therefore an 'outsider'. The issue of younger researchers interviewing older women has not been extensively

considered in the existing literature. This is, in part, because research in the gerontology field has typically been conducted by older researchers. As Walker (2007, p.58) notes:

> 'traditionally, research with older people, especially from a feminist standpoint, has been undertaken by older people themselves who have reflected upon their own experiences in an attempt to move closer to their subject and develop close, personal relationships with their study cohort'.

However, Stöckl *et al*. (2012, p.2561) suggest that, due to their upbringing, exposure, and the shame and isolation associated with intimate partner violence, older women are less likely than young women to talk openly with outsiders about their intimate relationships and might find it harder to report violence to a researcher (Hagemann-White, 2001). I was therefore concerned prior to interviews about the impact my age might have on the process and whether the older women may be reluctant to share their experiences with a much younger researcher.

Although my age was not disclosed at any point before interviews or during interviews (because participants did not ask) I was aware throughout of the age differences between us and that I was asking these women, who were a similar age to my grandmother, to disclose personal details about a sensitive, and possibly traumatic, experience. I felt very aware of the age gap between us, despite none of the women mentioning it themselves. However, despite my initial concerns that older women may feel uncomfortable disclosing details of their experience, particularly in light of the interviews with practitioners in Phase two where the age of practitioners was described as a key issue for older survivors who found it difficult to engage with younger counsellors or support workers, I found the women very willing to speak to me. Many spoke about their children being a similar age to

me and they seemed to enjoyed asking me questions about my life and comparing that to their own, and their children's. For example, one of the women noticed my engagement ring and was very keen to hear about my wedding plans, and told me all about her own daughter's recent wedding. I actually felt my age helped to build rapport and trust. As Wray and Bartholomew (2010) found in their research, the younger age of the two researchers did not increase their outsider status as expected. Unexpectedly it meant that the participants described their experiences of past events in more detail because they assumed the researchers were too young to have first-hand experience of them. As such, the data that was generated was perhaps more in-depth than it would have been if the participants and researchers had been of a similar age. Although I cannot be sure that this was the case in my research, I did not feel my age acted as a barriet to interview the three women survivors.

3.6.2 Emotional impacts

Undertaking sensitive research can have a range of emotional impacts on the wellbeing of the researcher (Campbell, 2002; Dickson-Swift *et al*., 2009; Ellsberg *et al*., 2001). Listening to the stories of women who have experienced sexual violence can be upsetting and difficult for the researcher, described by Carroll (2013) as 'emotional labour'. Although I have previous experience of interviewing women about their experiences of domestic and sexual violence, and hearing stories of high levels of physical violence and the impact and consequences of this on women, I did find one of the survivor interviews in particular very difficult to listen to.

Although the specific details of the rape were not asked for in any of the interviews, all three women divulged some information about the assault. One of the survivors (Jennifer) was raped by two men and the rape involved significant physical violence which resulted in a multitude of physical, and

psychological, injuries and harm. Hearing her story, which she shared in a lot of detail, was very difficult and I felt both shocked and upset at the details, particularly where the perpetrators had purposely inflicted pain on Jennifer as part of the rape. Hearing how this had impacted her and continued to affect her physical health was also upsetting. The fact that only one of the perpetrators was found guilty at trial was infuriating. Ellsberg *et al*. (2001) report that interviewers in their study found listening to women's stories deeply distressing. I replayed the details Jennifer had shared with me over in my head continuously as I drove the two and half hours home after our interview and have thought about them on many occasions since. Researching in the area of violence against women can sometimes reduce sensitivity to the stories of survivors, as they become almost normalised, however hearing Jennifer's experience was a shock to me and served as a stark reminder about the levels of violence women experience at the hands of men. It made me even more passionate and committed to research and activism in this area, particular for older women, as their stories have, to date, not been included in the research. It reminded me why the research is so important, and giving a voice to older women who have experienced sexual violence is critical.

3.7 Summary

This chapter has described the research methodology including an explanation of the research framework and the research design and a detailed description of the research process, the sampling strategies utilised and the methods adopted for data collection. The benefits of combining methods in a mixed-method approach have been highlighted. This chapter also explained the approach taken to analyse the quantitative and qualitative data, and the key methodological and ethical considerations of undertaking sensitive research with survivors of sexual violence and older people. This chapter concluded with some reflections on interviewing older survivors of sexual violence, in particular researching older women as a younger woman and the emotional impacts of speaking to

women about their experiences of sexual violence. The next chapter discusses the research findings. These are presented in a series of three chapters, each of which present the empirical findings and conclude with a discussion in light of the existing literature. The first of these chapters (Chapter four) reveals the findings from Phase 1 of the research based on FOI requests to police forces in the UK, examining the extent of recorded rape and sexual assault by penetration offences involving a victim aged 60 or over and the nature of these offences, including victim, perpetrator and offence characteristics.

Chapter 4: Phase 1 – The extent and nature of reported rape involving a victim aged 60 or over in the UK

4.1 Introduction

The prevalence or extent of sexual violence has been researched internationally (WHO, 2013), however very little is known about the prevalence of sexual violence against people aged 60 and over. As discussed in Chapters one and two, in the UK, the CSEW only asks people aged under 60 about their experiences and there has only been one study in the UK which specifically aimed to estimate national prevalence (Ball and Fowler, 2008). However, this study is limited to data from one police force which was extrapolated to give a national estimation which is unlikely to give an accurate figure, as recording systems and population demographics from the single police force area are not necessarily generalizable to the rest of the UK. Thus, one of the primary aims of this research was to provide a more accurate picture of the extent of recorded sexual violence in the UK. In this chapter, the data from responses to FOI requests from 45 police forces are presented, specifically; the number of recorded rape offences involving a victim aged 60 or over at the time of the offence; the gender and ages of perpetrators and victims; the ethnicity of perpetrators and victims; the victim-perpetrator relationship; the location of offences; the number of cases involving serial offenders; and the number of cases linked to another offence. The chapter will conclude with a discussion of the key findings and how these compare to the existing research on younger, and older, sexual violence survivors. It is argued that the findings challenge the 'real rape' stereotype (Chapter 1.6) which dominates discourses around sexual violence and contribute to researcher and wider societal ignorance of the victimisation of older women.

4.2 Recorded offences involving a victim aged 60 and over

The FOI data revealed that around 130 reports are made to the police annually for rape and sexual assault of older victims. The overall number of reported offences involving an older victim was low when compared with younger age groups. Table 1 shows the overall number of recorded rape and sexual assault by penetration forces and the proportion involving an older victim:

Table 1. Number of reported rape and sexual assault by penetration offences 1st January 2009 – 31st December 2013

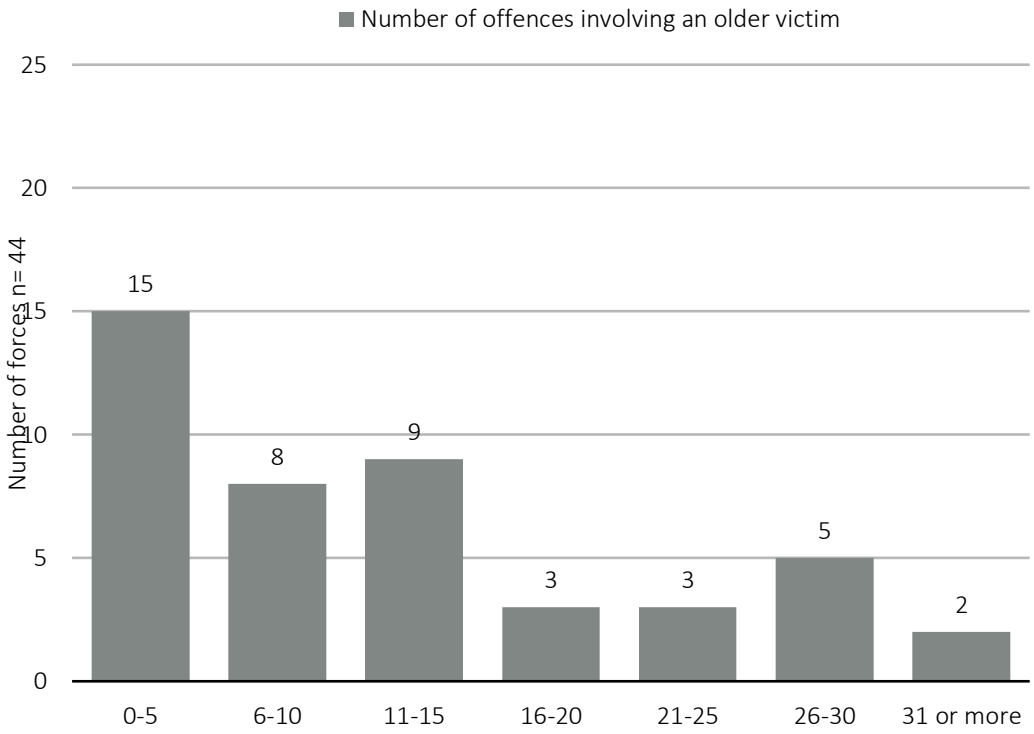
	Rape	Assault by penetration	Total
All ages	74,036	13,194	87,230
Victims 60+	474	181	655
Proportion	0.6%	1.4%	0.75%

The total number of recorded rape and sexual assault offences between 1st January 2009 and 31st December 2013 by the 45 forces that responded to the request was 87,230. The number involving a victim aged 60 or older at the time the offence was committed was 655, representing 0.75 per cent of the total recorded number. Rape was the more common offence to be recorded, both for all ages and specifically for cases involving older age groups. However, it is interesting that the total proportion of cases of sexual assault by penetration involving a victim aged 60 or over was more than double (1.4 per cent) than rape cases (0.6 per cent).

The number of recorded offences involving an older victim varied significantly by the force area. Figure 1 shows the distribution of offences. As the graph shows, the majority of forces (n=18) recorded between one and nine rapes or sexual assault by penetration offences involving a victim

aged 60 or over at the time of the offence between 1 January 2009 and 31 December 2013. Four forces recorded thirty or more offences (Greater Manchester Police, West Midlands, Essex and the Metropolitan Police). The lowest number of offences were recorded by the City of London, which is unsurprising given that, at just over one square mile, it is the smallest territorial force area in the country. Bedfordshire also had no recorded rapes involving an older victim in the research period, although they did record one sexual assault by penetration.

Figure 1. Distribution of offences recorded by forces 1st January 2009 - 31st December 2013



4.3 Victims were generally female and perpetrators male

Most victims were female and most perpetrators were male. Reflecting the existing knowledge on younger populations, sexual violence against older people is similarly gendered. The vast majority of victims were female (92 per cent), which reflects the national statistics. Men were victims in seven

per cent of cases, a slightly lower figure than reported in national police-recorded figures on rape and sexual assault (11.5 per cent).

Data on the gender of the perpetrator were available from 41 forces, relating to 570 offences. In 73 cases, the gender of the perpetrator was unknown. The main reason for this was that the crime was still undetected and no suspect had yet been found. For the remaining 497 cases, the vast majority of perpetrators were male. Overall, just 12 cases (two per cent) involved a female perpetrator. At least four of those cases also involved a male perpetrator. Table 2 provides a breakdown of the gender of the perpetrator in the recorded offences.

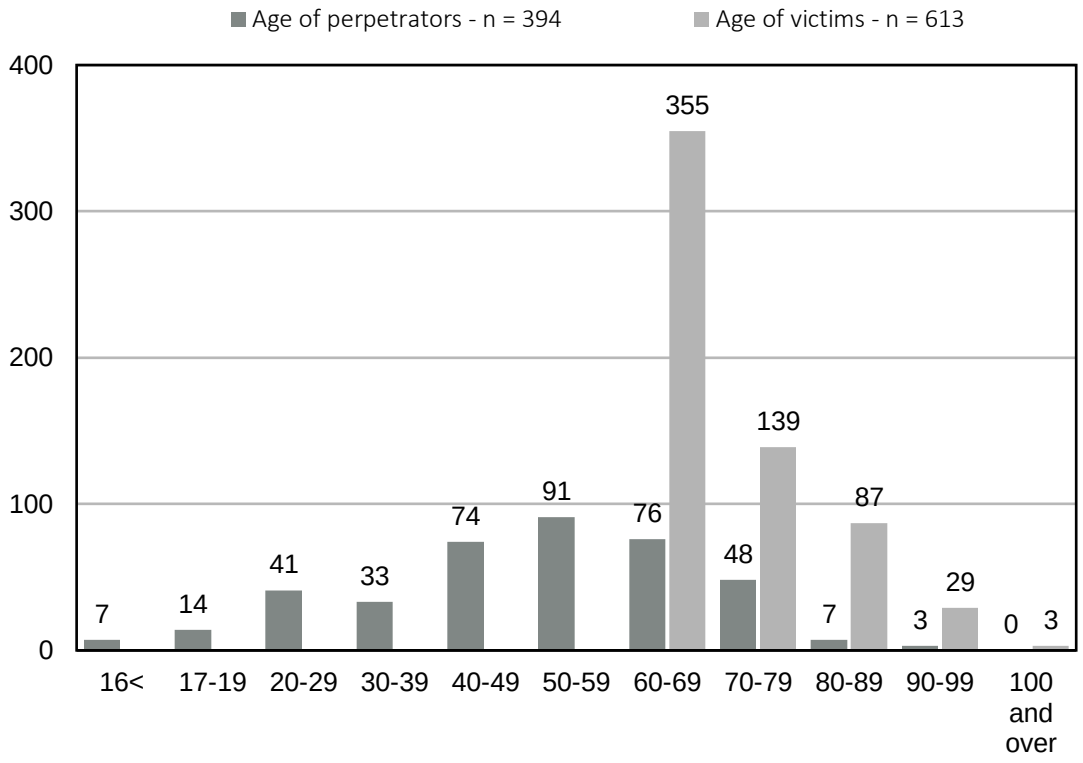
Table 2. Gender of perpetrators		
Gender	n	%
Male	485	85%
Female	12	2%

4.4 Perpetrators tended to be younger than the victims

Most perpetrators were younger than the victims. Perpetrators were most likely to be younger than their victims. Figure 2 shows the breakdown of both victim and perpetrator age groups and the corresponding number of offences. There was more available data on the victim characteristics than offender characteristics as in some of the cases the crime had not yet been detected or the age of the offender had not been recorded in the police file. However, the available data show that victims were most likely to be raped or sexually assaulted by someone younger than them. The vast majority

of offenders were aged under 60 (66 per cent) and offenders from aged between 40 and 59 accounted for 42 per cent of cases. Victims by contrast were aged between 60 and 98, with the majority in their 60s and 70s.

Figure 2. Age of victims and perpetrators



4.5. Victims generally knew the perpetrator

Most perpetrators were known to the victim. The most common relationship was acquaintance (26 per cent), followed by partner or husband (20 per cent) and stranger (20 per cent). Table 3 provides a breakdown of the relationship types emerging from the data. Hence, the majority of victims knew the perpetrator, consistent with national data that estimated that 80 per cent of victims know their perpetrator. However, whereas national statistics (ONS 2015) report the majority of perpetrators are partners or ex- partners (47 per cent), followed by other family members (33 per cent), the

present study found that the broader category of 'acquaintance' was the most common relationship, followed by partner. Most of the assaults were perpetrated in the victim's home.

Table 3 - Relationship of victims and perpetrators		
Relationship	n	%
Partner or husband	108	20%
Child	4	1%
Grandchild	2	>1%
Other family member	18	3%
Unrelated carer	67	12%
Friend	20	4%
Neighbour	16	3%
Acquaintance	143	26%
Stranger	103	20%
Other	10	2%
Unknown	50	9%
Total	541	100%

4.6 Both victims and perpetrators were generally white

Overall, data on the ethnicity of victims were available for 375 cases. In the vast majority (80 per cent) of cases the victim was described as 'white', which included those who were white British, white European or white 'other'. A further 11 per cent were described as 'British'. Four per cent were 'Black/Afro-Caribbean' and three per cent were 'Asian'. In terms of perpetrators, data on ethnicity

were available for significantly fewer cases (n=139). Again, the majority were 'white' (67 per cent) and a further 18 per cent were 'British'. Only two cases involved a 'Chinese' perpetrator, three were 'Asian' and a further three were 'Asian Pakistan'. Only one perpetrator was categorised as 'Black/Afro-Caribbean'. Therefore, the vast majority of both victims and perpetrators were white. However, as this data involves offences recorded to the police, these findings may reflect the cultural barriers to reporting to authorities (which may include distrust of the police, language barriers or isolation)

4.7 The majority of offences took place in the victim's home

The majority of offences were committed in the victim's home. Table 4 provides a breakdown of the location of offences. Unsurprisingly, the most common perpetrator of offences that occurred in a care home was an unrelated carer.

Table 4 - Location of assaults		
Location	n	%
Victim home	299	54%
Perpetrator home	38	7%
Victim and Perpetrator home	36	6%
Care home, hospital or nursing home	117	21%
Public outside	26	4%
Public indoor	9	2%
Other	16	3%
Unknown	15	3%
Total	556	100%

Table 5 provides a breakdown of victim and perpetrator relationship and location of the offence in the available cases.

Table 5 – Relationship and location of assaults							
	Victim Home	Perpetrator Home	Victim and Perpetrator home	Care home	Public indoor	Public outdoor	Total
Partner/spouse	46	2	20	6	1	0	75
Acquaintance	59	10	0	16	0	4	89
Un-related carer	26	3	0	25	1	0	55
Child or Grandchild	3	0	0	0	0	0	3
Neighbour	8	1	0	3	0	0	13
Stranger	35	2	0	14	11	3	65
Friend	5	2	0	0	0	0	7
Other	11	3	0	3	0	0	17
Not provided	43	2	1	18	1	0	83
Total	236	70	21	85	14	7	433

The type of relationship had obvious links to the location of the assault. Where the offence took place in the victim's or perpetrator's home, the perpetrator was most likely to be an acquaintance or partner to the victim, whereas where the offence occurred in a care home, the most likely perpetrator was an unrelated carer. However, it is interesting to note that despite care homes being the second most common location, in the overall sample unrelated carers were the fourth most

common relationship group, suggesting a significant proportion of the rapes in care homes are perpetrated by people other than carers - possibly by other residents or by visitors to the care home.

4.8 Serial sex offenders

Forces were asked to indicate where an offender in any of the cases involving an older victim was a known serial offender, i.e. where they had committed other sexual offences. In only 14 cases were the suspects or perpetrators identified as serial offenders. However, in 216 cases it was not recorded or unknown whether the suspect or identified perpetrator was a known serial offender. Details of the other offences committed by these perpetrators was not requested. In the 14 cases, perpetrators were most likely to be a stranger (36 per cent). Perpetrators were most likely to be aged 50-59 (57 per cent) and the most common location was the victim's home (79 per cent).

4.9 Links between the rape and another recorded offence

Forces were asked to indicate where the rape or sexual assault by penetration offence was linked to another, recorded offence. Very few of the sexual offences were also linked to another crime. Overall, 51 of the cases had a positive link to one or more other offences. Details of the type of secondary offence was not requested, however two forces did provide details for two cases that were linked to a secondary crime. In those cases, the crimes were assault (by the suspect toward the victim) and theft of money. However, in 119 cases it was either unknown or not recorded whether the rape was linked to any other crime.

Of these 51 cases, perpetrators were most commonly aged 60-69 (20 per cent) and 20-29 (20 per cent) and the most common victim-perpetrator relationship was 'carer' (22 per cent) followed by

'partner' (20 per cent). The most common location was the victim's home (43 per cent) although in 13 cases the location was unknown.

4.10 Discussion

These findings share some similarities and differences with the existing understandings of sexual violence against younger age groups, as well as the existing pool of research, which has specifically looked at sexual violence against older women, and the broader research situated within elder abuse. In line with existing knowledge of rape against younger populations, the majority of victims in the present research findings were female, whilst the vast majority of perpetrators were male. This also mirrors the previous UK research on sexual violence against older women (Ball and Fowler, 2008, Jeary, 2005, Lea *et al*., 2011) and literature from the elder abuse field (Gorbien and Eisenstein, 2005; Naughton *et al*., 2010; O'Keeffe *et al*., 2007).

The overall proportion of rapes and sexual assault by penetration offences involving a victim aged 60 or over were low compared to those aged under 60 – just 0.6 per cent and 1.4 per cent respectively of all of these offence types recorded by the police. The numbers reported in this study are slightly lower than those reported in the only other similar study conducted in the UK (Ball and Fowler, 2008). However, the present study had a much narrower focus on the two most serious forms of sexual violence, whereas Ball and Fowler's study looked at all sexual offences committed within a five-year period at a single police force in a semi-rural English county and thus it is likely if all sexual assault were looked at the numbers would have been much higher than reported in the present study. This is supported by Ball and Fowler's study, which found that less than half the reported sexual offences in their data were rape or sexual assault by penetration. Furthermore, existing research from domestic violence and elder abuse fields suggest older women are even less likely to report sexual

and domestic victimisation than younger populations (Pillemer and Finkelhor, 1988; Rennison and Rand, 2003).

It is widely accepted that victims of rape and sexual violence are disproportionately female whilst the majority of perpetrators, regardless of the victim's gender, are male (Home Office, 2013). For example, the latest national statistics estimate that 20 per cent of women experience some form of sexual assault at some point in their life, compared to less than five per cent of men. Furthermore, the majority of victims of both genders reported their offenders were men (99 per cent). The present study mirrors these national findings, and the specific 'sexual violence against older people' literature in finding that the vast majority of victims were female and the vast majority of perpetrators were male. In the small number of cases involving a male victim, perpetrators were also male in the majority of cases. This furthers the argument that gerontological approaches to understanding sexual violence in older populations are limited as they prioritise age as the dominant issue and present the phenomenon as gender-neutral. The importance of gender cannot be ignored; in keeping with both the sexual violence literature and the broader elder abuse literature, women face significant and disproportionate levels of victimisation and perpetrators are almost always male. Thus, a feminist-gerontological analysis of these issues is crucial, which considers not only gender, but age. Women continue to be disadvantaged whilst men continue to exert power and domination. Whereas the elder abuse framework has tended to prioritise age as a risk factor or cause or abuse against older people, and feminist research has focused on gender as the primary factor in intimate violence, this research has shown that both regardless of the age of the victim, women are disproportionately victims and men are perpetrators in the vast majority of cases even where the victim is also male.

Similar to the rape literature on younger populations (Home Office, 2013), the majority of victims and perpetrators in reported cases involving a victim aged 60 or over in the last five years were self-defined as 'White' with very few victims or perpetrators from black or other minority ethnic groups. Again this is echoed in the existing older sexual violence research (Ball and Fowler, 2008; Lea *et al*., 2011; Scriver *et al*., 2013) and elder abuse literature (Naughton *et al*., 2010; O'Keeffe *et al*., 2007). This is likely to reflect barriers that make it even more difficult for minority ethnic groups to report to the police.

However, there are a number of differences that have emerged in the present study from the existing fields of literature on sexual violence against older women and existing media reports. These findings challenge the 'real rape' stereotype of older women that has developed in some existing research and in the media reporting of cases. According to this model, older rape victims are usually female and attacked by a stranger, considerably younger than they are, usually in the victim's home (or a care home) or in an outdoor public location. This model exhibits similarities with the prominent 'real rape' myth of younger women, which also centres around a stranger rape on a female victim, usually in an outdoor location but sometimes in the victim's home or elsewhere. Research and policy has focused efforts on challenging this myth in relation to younger women and statistics have debunked the main components of this stereotype by revealing the majority of victims are raped by someone they know, typically a husband or partner, or acquaintance, and usually the rape takes place in the victim's home. This research does the same for older victims.

In contrast to the 'real rape' stereotype, the present study found that women aged 60 and over were most likely to be raped by an acquaintance, a partner or husband, or someone else known to them. This is contrary to the dominant media reports and research findings, which have primarily

concentrated on stranger rape cases. In particular, there is a notable gap in the existing research and media reports in relation to cases involving a partner or husband. Despite research around younger rape victims revealing partners or ex-partners being one of the most common categories of perpetrators (Home Office, 2013), in relation to older people there is a clear absence of these cases in existing research and virtually no reported cases in the media. This similarity with younger age groups is particularly important as it challenges the existing depictions of rape of older women which has positioned it as a distinct form of abuse, different to sexual violence against younger women and to some extent has justified the absence of older women in feminist sexual violence research and discourses (Jones and Powell, 2006; Whittaker, 1995). However, as Whittaker (1995) argues, the dynamics which characterise sexual violence in younger populations are likely to be the same in older populations and therefore a distinct analysis of sexual violence based on an age model is unnecessary and depicts abuse to be, at least partly, the victim's fault for being 'old' (Whittaker, 1995).

In a significant minority of cases, the perpetrator was known to the victim as their carer, a relationship which has unique dynamics and warrants further investigation in future research, particularly in light of the fact that other research in this area has not reported on carers as perpetrators (Ball and Fowler, 2008; Jeary, 2005; Lea *et al*., 2011). Whilst this has been considered to a larger extent in the elder abuse literature, the focus has generally been on financial and emotional abuse perpetrated by carers; sexual abuse perpetrated by carers is a neglected area across all disciplines.

The number of stranger rapes in the present study was similar to the statistics around younger rapes. In the present study, 20 per cent of reported cases to the police involved a stranger, compared to 15 per cent of cases reported in the CSEW (Home Office, 2013). This is contrary to the research findings of a number of studies exploring sexual violence against older women. A number of early studies

emerging from the US suggested older women were most likely to be raped by a stranger, typically much younger than them in their own home (Groth, 1978; Pollock, 1988; Hicks, 1978; Davis and Brody, 1979; Muram *et al*., 1992; Burgess *et al*., 2007). In the UK, research by Jeary (2005) also found that, in around two thirds of their sample, the offender was not known to the victim. Ball (2005) in reviewing the existing research thus concluded that older women were most likely to be raped by a stranger. The media, both in the UK and elsewhere, perpetuates the myth that a stranger typically rapes older women. For example, headline stories in 2015 included the gang rape of a 70 year-old nun in India (Guardian, March 2015; Independent, March 2015) and the rape of an 87 year-old woman in California (NY daily news, 2015; Daily Mail, 2015) and the rape of an 84 year old woman in Manchester (Manchester Evening News, March 2015; International Business Times UK, March 2015). All of these examples involved perpetrators who were strangers to the victim, and all were young men (the majority of these were teenagers).

It is therefore interesting that the present study found significant differences to the early work in both of these areas. However, it does reflect the emerging 'domestic violence against older women' literature which has found sexual violence to be a key form of abuse continuing into old age for many women (Ferreira-Alves and Santos, 2011; Stöckl *et al*., 2012; UN, 2013). Furthermore, more recent elder abuse studies have reported that interpersonal violence (which includes physical and sexual violence) is most likely to be perpetrated by a partner or spouse (O'Keeffe *et al*., 2007).

Similar to what we know about cases involving younger victims, the present study found older women were most likely to be raped in their own home. This mirrors previous research in this area (Ball and Fowler, 2008; Lea *et al*., 2011) and is supportive of the finding that perpetrators were generally known to victims. Interestingly, even in stranger cases, the majority of rapes were perpetrated in the

victim's home. However, a significant number of rapes were perpetrated in care homes, by strangers, carers and acquaintances, which poses unique considerations for care providers and nursing homes as well as safeguarding policy and practices.

One of the key differences in relation to older rape cases compared to younger cases that emerged in the present study was the age of the perpetrator. National statistics over the last decade, along with smaller research reports, have revealed that the majority of perpetrators are older than victims. However, in the present study, the overwhelming majority of perpetrators were younger than victims. The most common age group for victims in reported cases was 60-69, whereas offenders were aged under 60, with those aged between 40 and 49 accounting for 42 per cent of cases. However, despite being overall younger than victims, offenders were not as young as in other research (Groth, 1978; Pollack, 1988; Jeary, 2005) and the speculations driven by earlier research and widespread media reports that perpetrators are usually significantly younger than their victims is not born out in this research.

4.11 Summary

This chapter presents the findings from the FOI requests, which were completed by 45/46 forces in the UK. In addition to the number of recorded offences involving a victim aged 60 and over, data was collected on the nature and characteristics of victims, perpetrators and offences. This data revealed a number of similarities and differences with the existing research on younger, and older, sexual violence victims and perpetrators. In particular, the findings challenge the 'real rape' stereotype that rape is exclusively a young person's problem. Significant findings including the age of perpetrators, who were generally younger than victims, and the location of assaults; care homes were the second most common location. The following chapter will outline findings from 23 practitioners who work

at sexual violence organisations and have provided support to older survivors of sexual violence and four practitioners working in age-related organisations. In particular, the following chapter presents the views and experiences of practitioners in relation to the impact of sexual violence on older people, the challenges and barriers to disclosing violence and accessing support, and the current gaps in service provision.

Chapter 5: Phase 2 - Views of practitioners

5.1 Introduction

A number of key organisations support sexual violence survivors in the UK; namely Rape Crisis centres, sexual assault referral centres (SARCs), and domestic violence refuges. Each organisation offers a range of support services, as described in Chapter Two. Rape Crisis centres focus on more long-term support, including counselling and independent sexual violence advocacy. SARCs provide more acute, short-term support such as forensic medical examinations and sexual health checks. Domestic violence refuges provide accommodation, support groups, counselling and practical health, financial and social support to victims of domestic violence (which can include sexual violence). These organisations can provide insights to the experiences of survivors, including barriers and challenges survivors of sexual violence face, the short and long-term impacts of sexual violence and the gaps in service provision. Age-related organisations and charities focus on providing support services to older people, often around social isolation, health and wellbeing and loneliness, although some specific organisations support older people who experience 'elder abuse'. As very little is known about the experiences and needs of older sexual violence survivors, this research aimed to explore older women's experiences of sexual violence and assess whether these differ from younger survivors' experiences (Research objective 3). What are the support needs of older womenwho have experienced sexual violence since the age of 60? Are these different to younger survivors? (Research objective 5) and finally, to what extent do staff and volunteers at specialist sexual violence organisations (e.g. Rape Crisis) feel competent in their ability to meet the needs of older women disclosing sexual violence? (Research objective 6). The interviews therefore focused on the experiences of practitioners in supporting older women, to examine how the impacts, challenges and

barriers older survivors may face impact on the support needs and how practitioners respond to this/the issues practitioners have experienced in providing this support.

This chapter provides the perceptions of practitioners working in sexual violence and age-related organisations in relation to these questions. The findings from interviews with sexual violence are presented first, followed by the views of age-related practitioners in section 5.9. It is important to stress at the outset that the challenges and impacts that practitioners describe are based on their experience with, and observations of, older survivors of sexual violence rather than the direct accounts of survivors, which are presented in Chapter six. These findings provide useful insights to the issues practitioners feel older people encounter following sexual violence, the challenges practitioners may face in providing support to older survivors based on these issues and subsequent needs, and the current gaps in service delivery, allowing for further research to examine these issues with survivors themselves and policy developments to support practitioners in providing their services to older people.

5.2 Participant demographics (sexual violence practitioners)

The participating sexual violence practitioners (n=23) worked in a range of organisations offering different support to survivors of sexual violence. The majority worked in Rape Crisis centres (n=12). The services offered at the centres differed slightly depending on the individual centre, but generally included telephone helplines, email support, face-to-face support (both one-to-one and group sessions), counselling, advice and advocacy. Most centres also had an independent sexual violence advocate (ISVA) who supports women through the criminal justice system. Most services were women only and were available to women aged 18 and over, however some services offered support

to girls and young women (the youngest starting age was 13) and some services offered support to male survivors.

Five participants worked in sexual assault referral centres (SARCs). The services offered are generally narrower than Rape Crisis centres and are focused on short-term immediate support following the rape or sexual assault. Some SARCs offered short-term counselling (usually a maximum of 10 sessions) whereas others offered no in-house counselling and instead referred to other agencies for this - i.e. Rape Crisis centres or hospitals/GPs. The main services at all the SARCs where practitioners worked were forensic medical examinations, storage of evidence and advocacy. Some SARCs had their own ISVA. The majority of SARCs were based on the same sites as police stations.

Four participants worked in a domestic violence organisation. These organisations offered a range of services to women who have experienced any form of domestic violence (physical, financial, emotional and sexual) including accommodation in refuges, counselling, one-to-one and group support, Freedom programmes, advocacy, independent domestic violence advocate (IDVA) who supports women through the criminal justice process, and mental health support workers.

Two participants worked independently as a trauma therapist and counsellor. Based in a room at their own homes, one offered support to male and female survivors of sexual abuse although they worked predominantly with male victims and the other practitioner worked exclusively with male survivors. Both offered one-to-one counselling and one of the practitioners also offered group support. Both practitioners signposted survivors to relevant organisations for other forms of support. One participant was a general practitioner (GP) who had also worked for more than three decades as

an independent forensic medical examiner, attending police stations, and later SARCs, to conduct medical examinations of women who reported rape or other sexual assault.

Twenty-one practitioners were female and two were male. The age of practitioners ranged from mid 20s to mid 60s, with the majority aged between 30 and 55.

The main referral pathways for the participating organisations were through GPs, police or self-referrals. The most common referral route varied depending on the organization – SARCs tended to get more police referrals and Rape Crisis centres tended to get more GP and self-referrals. Similarly, domestic violence organisations tended to get referrals from GPs or other healthcare professionals or through self-referrals. The two independent therapists got most of their referrals through GPs.

The structure of the participants' organisations also differed. SARCs tended to be run by paid members of staff, whereas Rape Crisis centres had a mixture of paid and volunteer staff. All of the participants' organisations employed a wide age-range of staff and volunteers, however some roles were more heavily dominated by younger groups, such as the telephone helplines, whereas counsellors tended to be slightly older.

Participants held a diverse range of roles, ranging from management positions including CEO, service manager, refuge manager, director of services and volunteer coordinator, to support-based roles including counsellor, forensic medical examiner, independent sexual violence advocate, helpline worker and support worker. Table 6 provides an overview of practitioner roles.

Table 6. Practitioner role and organisation type		
Practitioner assigned letter	Practitioner role	Practitioner organisation
A	ISVA and IDVA	Rape Crisis Organisation
B	Clinical Lead	Rape Crisis Organisation
C	Independent Trauma Counsellor	Sexual Violence
D	CEO	Rape Crisis Organisation
E	Forensic medical examiner	SARC
F	Volunteer Coordinator	Rape Crisis Organisation
G	Counsellor	Rape Crisis Organisation
H	Helpline advisor	Rape Crisis Organisation
I	Independent Trauma Counsellor	Sexual Violence
J	Service Manager	SARC
K	Volunteer coordinator	Rape Crisis Organisation
L	Counsellor	Rape Crisis Organisation
M	Refuge Manager	Domestic Violence
N	Support worker	Domestic Violence
O	Manager	SARC

P	CEO	Rape Crisis Organisation
Q	Support Worker	Domestic Violence
R	Manager	SARC
S	CEO	Rape Crisis Organisation
T	Information and advice support	Domestic Violence
U	Director	Rape Crisis Organisation
V	CEO	Rape Crisis Organisation
W	GP	SARC

The majority of participants' organisations were based in urban areas within large towns or cities, however several participants worked in rural locations or in organisations that offered services across large geographical areas, which incorporated urban areas, and two participants worked in areas characterised by particularly high numbers of retired inhabitants.

5.3 Practitioners had limited experience of supporting older survivors

All of the participating practitioners stated the number of people aged 60 or over accessing their services was low compared to younger groups. Sexual violence organisations estimated between one and 10 per cent of their service users in the last five years had been aged 60 or over, however the majority of those were accessing support for historic abuse. In terms of survivors accessing for recent sexual violence (since the age of 60) most practitioners estimated they have seen less than 10

older women over the previous five years who had experienced sexual violence in later life. In general, SARCs had more contact with older survivors than Rape Crisis centres and domestic violence refuges or independent counsellors (working on a self-employed basis). The oldest woman seen by the participants was 97, however the majority were in their 60s or 70s.

Practitioners said older survivors accessing the sexual violence organisations had experienced sexual violence in a diverse range of contexts. Most of the women had been raped by a single perpetrator and practitioners said in most of the cases the victim knew the perpetrator, however there were some cases of rape by strangers and some by family members, including sons and grandsons. Very few of the cases practitioners said they had seen had involved sexual violence by a husband or partner. A small number of cases had involved rape in care homes (five were specifically mentioned by practitioners), either by another resident or care home staff. In the vast majority of cases, the victims were women and the perpetrators male, however some participants had supported male victims of rape or sexual violence; in these cases, the perpetrators were also typically male. Again, the contexts ranged but most of the male victims had been raped by a carer or acquaintance, in either a care home or their own home.

The services offered by sexual violence participants' organisations were open to all women (usually over the age of 18) with no upper age limit. All participants said the support available to older women was exactly the same as that offered to younger women, but stressed that all of the services were adapted to the individual's needs rather than having specific services for women from particular backgrounds. As such, none of the participants' organisations offered anything specific for older survivors. However, several practitioners said they would try and get an older client seen more quickly and referred into appropriate services because of their age and potential vulnerabilities (for

example physical health or mental health issues, disabilities, etcetera). One of the main things practitioners felt was important for supporting older women was accessibility:

> '[We] try and be as accessible as possible, really important for older women. Women in their 70s don't want to travel, so [we] see them in their GP surgery. [We] rely on goodwill of other organisations to use free of charge premises we have assessed: library, youth centre, county council venues etc.' (Practitioner J)

Although not specific to older survivors, outreach services were highlighted by some practitioners as a service used more by older clients as they were more likely to have mobility problems or other issues which created challenges for them accessing support at centres. For example, one centre said they offered an outreach service at local community premises such as GP practices and libraries and said this was most often used by older clients who felt uncomfortable going to the centre or were unable to because of mobility issues:

> 'One to one counselling, advocacy, ISVA, emotional support and helpline. We are reactive here, with the call or referral as they come in, [we] work individually with each woman. We have recently set up a young people's group because we are fortunate to have a young persons' worker. But everything else that is across the board.' (Practitioner G)

5.4 Impacts of sexual violence on older survivors

A range of negative impacts of sexual violence on older survivors had been observed by all practitioners who had worked with older women over the previous five years. These can broadly be categorised into physical, emotional and lifestyle impacts. Whilst they are presented here in these

separate categories, in reality all three overlapped and practitioners explained that survivors had typically experienced a range of these impacts.

Physical impacts were generally linked to the trauma of the sexual violence and included genital injuries, broken bones, bruising and cuts. Some of these then created long-term health conditions, for example incontinence, or exacerbated existing injuries or conditions such as arthritis. In one case a practitioner gave an example of a pre-existing condition that had been deliberately worsened during the attack:

> 'Yes, they all have [physical impacts]. Mostly arthritis, rheumatoid arthritis, something we naturally associate with old age. There was one, some injury or rheumatoid arthritis in his shoulder and he was being raped and this guy kept moving his shoulder to make him scream, because he didn't scream when being penetrated, so he made him scream by moving his shoulder.' (Practitioner C)

The severity of violence used during the attacks was a common theme, a characteristic reported in the earlier studies by Groth (1978) and more recently Jeary (2005). Nearly all the practitioners said the women they had seen had experienced significant physical violence, above and beyond what was required to dominate the victim:

> 'One thing alarming about perpetrators who target older women is that the rapes are quite ritualistic and violent and sinister.' (Practitioner B)

Another example of severe violence was provided where an elderly female was raped by a younger acquaintance who broke both of her hips during the rape. As a result of the violence, injuries were usually more severe and took longer to recover from. In some cases, the attacks led to a range of long-term health complications:

> 'One woman experienced her first sexual violence in 2013 having had nothing prior to this and at the time she was 71. By the June of 2014 she was diagnosed with depression and PTSD, had 2 heart attacks in that time, and was nocturnally incontinent.' (Practitioner A)

However, it may be that cases involving high levels of physical violence are more likely to be reported and survivors more likely to seek support for these types of rapes.

A range of negative emotional impacts were also described by all practitioners. Many of these were similar to those observed in younger survivors, for example Post Traumatic Stress Disorder (PTSD), depression, anxiety, sleep disturbance, and stress. However, all practitioners felt these were often amplified for older women because of their age and a lack of other opportunities in their life, for example employment or future relationships. Furthermore, several practitioners had seen the mental health of older survivors decline over time, potentially linked to their physical ill health. One practitioner explained the survivor declined:

> 'Both mentally and physically. When I first started working with her, she was quite spritely, baking me cakes, by the end she was physically hunched over and lost an incredibly large amount of weight.' (Practitioner A)

Both the physical and emotional effects of sexual violence resulted in a number of lifestyle impacts for older survivors, in particular becoming agoraphobic leading to social isolation, difficult relationships with family or friends and disengaging with other organisations, such as health providers. One practitioner gave an example of an older woman who was raped on holiday:

> 'I think [the impacts are] different to younger women, i.e. the woman I worked with will never go abroad again; for younger women it is easier to move on but older women will totally change their behaviour.' (Practitioner V)

Practitioners had observed a number of coping strategies adopted by older survivors. Many of these were similar to younger survivors, for example taking prescription medication for pain relief or depression. However, six practitioners felt alcohol was used more often by older survivors as a coping mechanism. As one practitioner explained:

> 'There are other things that need to be considered, one of the things is their coping mechanisms. They will use alcohol as a way of coping which induces a lot of shame. They feel uncomfortable accepting they use this as a way to cope.' (Practitioner B)

These practitioners felt it could be more challenging trying to address pathogenic coping strategies in older survivors because they were more established due to the length of time the survivor had relied on them as a strategy to manage everyday stress or previous traumatic experiences. However, this is based on a very small number of cases and there is not enough evidence to establish cause and effect.

5.5 There were overlapping challenges in terms of accessing support and providing support

Practitioners shared a number of observations about the challenges that older women have faced in their experiences of working with them. These challenges created barriers for survivors accessing support and also created a number of considerations for practitioners in terms of adapting their services. These can be broadly categorised into three groups: physical challenges; emotional or psychological challenges; and societal level challenges.

5.5.1 Physical challenges

All of the practitioners had observed a range of physical challenges experienced by older survivors, which centred around poor physical health, which may be pre-existing or as a result of the sexual violence. In particular, physical disabilities were cited as a major challenge for older survivors accessing support:

> 'I think they are more likely to have more health issues. It may be that we have to think about access and that sort of thing, it could be they are more hard of hearing, may need more support getting to the centre. The older you get the more difficult it is to access.' (Practitioner D)

For practitioners offering services in SARCs, physical disabilities could create challenges for both the survivor and the practitioner:

> 'Physical disabilities, to do forensic they need to climb on couch, open legs etcetera. Just physically managing them in an environment, arthritis or physical conditions limiting mobility,

emphysemic, again they are limited with getting to the SARC so might have to see them in their own home, which isn't forensically ideal.' (Practitioner E)

Furthermore, where survivors had pre-existing conditions or where they developed health problems after the sexual violence (either related or un-related) practitioners felt this could make it even more difficult for older women to access support.

Other physical disabilities described by practitioners, which created challenges for survivors, were sight or hearing impairments and conditions. However, whilst all practitioners felt physical disabilities could create barriers for survivors accessing support, they did not feel it impacted negatively on their ability to provide support in general, as it was stressed from the outset by practitioners that all of their services were tailored to individual needs, and many younger survivors had access requirements or specific service needs. All of the practitioners' organisations were accessible to those in a wheelchair and all had a range of alternative support formats, for example leaflets and information in braille and in minority languages. However, practitioners did state that they had offered outreach services to significantly more older, than younger, people over the previous five years based on the needs of the individual, based on the issues identified above, which left the survivor housebound (either because of physical disabilities, poor physical health or mental health problems). Furthermore, several practitioners (counsellors, support workers and forensic medical examiners) said they had provided outreach support in the care home where the older survivor was based, which they felt was an age-specific need.

5.5.2 Psychological challenges

Emotional and psychological challenges were broadly similar to those experienced by younger survivors, including shame, fear and anxiety and self-blame. However, practitioners felt this may be magnified for some older women because of generational norms and values and societal attitudes towards older people:

> 'The stigma that they are older. The shame - again it is a generational thing they keep it from their children and having to go through that process. The whole process is horrific and for an older woman, having swabs and people coming and looking at your body. There is a different embarrassment attached to it when you are young.' (Practitioner F)

One significant barrier, which is specific to older age groups and was a primary concern for practitioners, was dementia. Seven practitioners had provided support to old survivors with memory function issues and some with diagnosed dementia, and this created barriers for the survivor and challenges for the practitioner. Practitioners were concerned that older people with dementia may not be believed when they disclosed abuse and may be dismissed by carers, family or professional bodies:

> 'We have had one with dementia related illness and she was very unwell with dementia and I think the trouble with that is that people tend to dismiss the presentation of something. I look at it that something must have happened that this person is bringing it up. Perhaps when they were able minded they couldn't talk about it because of the stigma. We are not there to disprove something.' (Practitioner L)

Furthermore, there are a number of specific ethical considerations for practitioners supporting those with dementia. For those providing physical examinations, there are issues around consent and the best interests of the survivor. As one practitioner explained:

> 'From a consent perspective how you manage a best interest decision can be challenging. To do an examination I should have informed consent. So if they have dementia and don't understand what I am doing and the implications, then you are having to do a best interests decision and then you are getting social services and those sort of people involved.' (Participant E)

Those who had provided counselling support stressed the need to weigh up the potential benefits and disadvantages of providing emotional support to people who struggle to remember the details of the sexual violence:

> 'I have two more which are linked to dementia. They had been raped but couldn't remember it and I was actually acting on behalf of someone else which I quickly brought to a halt because there was no value - whenever we got anywhere near, with the chap having memory problems, it had no value. There are problems when you are dealing with Alzheimer's or dementia that to constantly remind this guy that he had been raped was totally wrong and it outweighed any benefits there was of telling him.' (Practitioner C)

There was concern among all practitioners about a lack of clear guidance or training in relation to managing these issues, in particular dementia where practitioners felt the least confident in supporting survivors and knowing the most appropriate services to refer to.

5.5.3 Societal challenges

A number of societal level challenges were described by practitioners as acting as broad, macro-level barriers, which may make it difficult for older women to access support for sexual violence. These centred on ageist attitudes and rape myths. The combination of ageist attitudes, which view older people as asexual combined with 'real rape' myths and stereotypes, which link rape to male strangers attacking young, attractive women at night were thought by all practitioners to have contributed to a lack of awareness or acceptance that rape can happen in later life and may mean older women feel unable to access support services and may exacerbate feelings of shame, embarrassment and self-blame. One practitioner referred to:

> 'Rape being a compliment – nobody would rape her because she is so old. People assuming older women won't get raped for that reason because they aren't sexually desirable.' (Practitioner H)

Practitioners felt this impacted negatively on older people being able to understand their experience and was one of the key areas counsellors and support workers said they worked on with older survivors:

> ‘I think they find it hard to conceptualise what has happened to them. Because of how they look at things and how they look at themselves. We all get to an age where we think we are past it, not attractive etc., so why would anyone want to engage in that? They see it firstly and foremost as a desire, not as something of control and manipulate.’ (Practitioner G)

Practitioners who worked with male survivors (n=2) felt this had been a particular issue for older male survivors, as the dominant rape myths are not only associated with physical attractiveness but also with gender – the ‘real rape’ stereotypes exclusively characterise victims as young women and perpetrators as young men.

Nearly all practitioners felt that the dominant real rape myths and ageist attitudes, which had resulted in a lack of awareness and acceptance that sexual violence occurs in later life, had to some extent been exacerbated by media stories and awareness campaigns which tended to narrowly focus on younger groups, particularly in relation to the night-time economy:

> ‘I think from a generational point of view it might be more challenging… I think younger people find it easier to report because there is a lot more in the media, soap operas, greater understanding of what an abusive relationship is, what consent is. Whereas people in the older generation don't necessarily consider it appropriate to report.’ (Practitioner O)

This could lead to older survivors finding it difficult to come to terms with their experience, because of the deeply embedded rape myths that rape is about youth and sexual desire. For example, one practitioner explained:

> ‘I think women have said to me it is not like I am a young attractive girl. But it isn’t about sexual desire. But I think women might feel there is a degree of safety because they are older and not sexually desired.’ (Practitioner V)

Five practitioners expressed the shock and distress they experienced working with older survivors and were uncertain about how best to support them. This further reinforces the need for awareness raising of sexual violence against older people as well as tailored training and support for those who work with older survivors. One practitioner admitted:

> ‘Personally [I] found it slightly harder, a hurdle I had to overcome as have always looked up to people who are older than me so quite difficult providing support to someone older than me.’ (Practitioner H)

Another practitioner who worked with male survivors also said he had found it hard to get past some of the shock and his own assumptions:

> ‘Over the years I have dealt with over 60s but tends to be historic abuse so on that level I was ok but I found it difficult to try and contextualize sometimes what had happened to 60 or over. I have less experience supporting older people with recent abuse. I don’t think there has ever been any real awareness around it which means there is no text I can turn to, no research. I am usually pretty good at looking at research – it just doesn’t exist. So I felt out of my depth. I felt some kind of training should be there.’(Practitioner I)

Counsellors felt it was particularly important to allocate an older practitioner with older survivors. They felt that this could help minimise some of the potential uncomfortableness that some older people had voiced at having to share details of the rape with someone much younger. One of the main issues practitioners felt were specifically related to older survivors' engagement with support services was the age of the practitioner:

> 'Once they come forward they usually want their key worker to be older, they don't want to be talking to younger members of staff.' (Practitioner M)

Practitioners felt that older survivors were generally more comfortable receiving support from older workers, particularly in relation to counselling. A number of reasons were cited for this. First, practitioners felt that older women may be uncomfortable sharing details of their experiences and the impacts with counsellors or support workers who were significantly younger than them and may be a similar age to their children or grandchildren. This was partly based on embarrassment but also because women's experiences of sexual violence and their experiences of support must be contextualised in their broader experience of their life and the generation in which they grew up in. Second, practitioners felt that younger practitioners may not have a full understanding of the lifelong experiences of women and some of the issues which may affect older women, particularly in relation to physical health. One practitioner gave an example of a woman she had worked with:

> 'The client I had who was in her 70s was raped and one of the things she said she liked was that I was older. She also went to quite a lot of groups and one of the things she said was that there seemed to be a lot of younger workers there and she personally found that harder, she had never disclosed to any of the workers because she felt they were too young.' (Practitioner V)

5.6 Life experiences can mean some older survivors have high levels of resilience

Despite the issues identified, all practitioners generally felt it was easier to engage with older survivors compared to younger survivors. Practitioners felt older survivors were more resilient, less chaotic and more reliable in terms of engagement with the service. For practitioners, they felt it was down to the individual counsellor or support worker and their own skills and personality which influenced how easy it was to engage with any survivor of any age group. However, in general it was felt that older survivors come to counselling or other support services with different expectations and more maturity, which makes it easier to engage. Some practitioners felt this was because of the communication skills older women have built from a lifetime of talking with people:

> 'I think it is harder with the younger generation. I work easier with older women but you have got to be adaptable and changeable to the client. Younger women tend to see you as the counsellor professional in the chair and trust is harder, they keep you at arm's length and are not great at communicating their feelings as much.' (Practitioner F)

Some practitioners felt this was because people over the age of 60 are more likely to have lived through the Second World War or been impacted by that, or other, wars and major national and international tragedies as well as more personal traumas. One practitioner referred to:

> 'The older you get, the more resilient you become at dealing with trauma in your life. They learned how to manage. A young person does not have the life experience.' (Practitioner D)

However, one practitioner stressed that age was not the key factor in supporting a survivor:

> ‘I don’t have an issue, they have their problems but because sexual violence is an area full of problems so problem solving is part of the role, whether it is a 13 year-old or someone with substance misuse or someone in their 60s they come with unique needs and challenges, so it is a personalised approach.’ (Practitioner V)

Some very positive stories of engagement were given by practitioners, including one case where a client had gone on to volunteer for the organisation:

> ‘One woman was 67 at the time [she was raped]. She initially didn't know what to do, she disclosed to a friend she had been raped. She had self-referred as wasn't sure whether to report to the police, she was worried about impact on family. She did actually report and got a successful conviction and she now actually volunteers for us, so she has engaged really well.’ (Practitioner O)

However, some had been less able to engage, either because of living arrangements, mental health or deeply embedded generational norms and values. One practitioner explained:

> ‘Our eldest female was 97 and she didn’t have any ongoing support from us, she was in a care home. She had an ISVA. Most do but there are some that don’t. I think we have had some older people who have not been able to consent and engage, because of dementia or whatever.’ (Practitioner O)

Another practitioner shared similar views:

> 'I think it can be difficult. I think it is good to have an understanding of the era that some of these women were brought up in. They have a different outlook. It is about being mindful of that and finding out from them, how it was for them when they were younger, their beliefs, religion, culture etc. If you are talking to a woman in their 70s and 80s it is a totally different era and having an understanding of how it was for them and why they might be thinking they are now is really relevant in how they are reacting now.' (Practitioner G)

5.7 Challenges with the Criminal Justice System

The majority (n=21) of sexual violence practitioners (and all of the age-related practitioners) felt older people would be less likely than younger victims to report sexual violence to the police. Two practitioners said they felt older people would be more likely, based on their own experiences with older women, however they were cautious about making this generalisation as they had only limited experience with this age group:

> 'In some ways I think more likely. I think there is more of a belief in the body but that is perhaps to do with the patriarchal society.' (Practitioner L)

One practitioner felt there was no difference between older and younger survivors:

> 'Neither more nor less than younger women. Same barriers as younger women – shame, fear, not wanting to go through court process, not wanting people to know, lack of proof.' (Practitioner M)

In general, a number of reasons why older people would be less likely report were cited. The stigma and shame of having been raped in old age, a lack of trust in the police, and a lack of awareness of their rights were the main reasons practitioners felt older people would be less likely to report. As one practitioner explained, older women may be:

> 'Less likely to report, which goes down to fact rape in marriage only crime since 1990s and grown up in era where women were second class citizens and didn't have the same rights. It is harder to admit it has happened and when you are older it is a very intrusive process to go through.' (Practitioner D)

Overall practitioners estimated around half of the older survivors they had supported had reported to the police. The main reasons why people had reported was because they were scared, they wanted justice and/or they wanted to protect other women from being raped. However, there were a number of reasons why women did not report.

Practitioners felt there were a number of barriers preventing older women reporting to the police, in addition to those faced by all victims, including embarrassment, shame, and fear of not being believed. Practitioners felt that the stigma of being raped in old age was a key reason older women did not report to the police. This is linked to the dominant rape stereotypes which depict rape to be based on sexual gratification and therefore young, attractive women are the most likely to be raped. Practitioners felt this made it difficult for women to report to the police (or disclose to anyone else). This was also linked to generational norms and values which, for many older women, may mean sex was not something openly spoken about and was a taboo subject. Likewise, sexual violence and

abuse were silenced subjects and were not generally discussed, which may make it difficult for women to talk about, particularly to official authorities:

> 'I think that it is the massive thing about being believed, being unable to say those words because they have never spoken openly about sex, about the process not understanding the process of how to report and who to. And fear of the police and what they do/mean.' (Practitioner K)

Similarly, practitioners felt that older women may be generally reluctant to report to the police because they may fear the police, particularly as they grew up in generations where the police were seen as authoritative:

> 'One of them did report to the police, again didn't work with her for long. It was quite a violent rape – vaginal and anal. I think she reported because she had to go to the doctors because of a problem after – her GP told her she must report.' (Practitioner V)

One practitioner described a number of barriers to pursuing cases through the CJS for older survivors and the experience of one survivor:

> 'Physical frailty, and less resilient. More scared that not going to be believed and more scared about the impact of describing what happened to them, find it hard to use the words, worried about impact on me listening to them. Not processing information so readily so in terms of court support I have done, trying to prepare them for trial, I was very aware that whilst they looked like they had complete comprehension they were actually struggling to process the

information. I was very concerned about her taking the stand in court. She was on there for 1.5 hours. She was offered break, water etc., but not offered any other concession. She requested I went into the stand with her, common process in Crown but not in Magistrates and they wouldn't allow that. They should have taken far more breaks. She wasn't processing what she was being asked. He got a 3-month community order and unlimited restraining order. Psychiatrist didn't turn up at trial and because psychiatrist didn't turn up they reduced the order to 5 years. But we were unable to tell her any of this because of her mental health.' (Practitioner A)

However, one practitioner felt older survivors may be more likely to get a positive conviction because juries may find them more believable:

'Older women might do better in front of a jury than younger, we like to see a victim, she is frail, old, vulnerable etc. Whereas with younger women they tend to hold them responsible.' (Practitioner B)

5.7.1 Overcoming these challenges

All of the practitioners felt that the police could do a number of things to encourage older women to report rape. The biggest thing was raising awareness. Practitioners said that the police campaigns tend to focus narrowly on specific groups, usually young people and alcohol, and the night-time economy. Practitioners felt this could re-enforce the rape myths and stereotypes and further marginalise older women. It was suggested by several practitioners that police campaigns should be

more diverse and think about a range of groups and that specific campaigns around older people should be considered:

> 'Campaigns like we mentioned before. Their campaigns are showing people out drinking. I think doing more around campaigning and showing older people to demonstrate this happens to anyone regardless of age or gender. I think support services and our org need to, perhaps a group approach, the police are showing this happens to anyone of any age and even if you don't want to report to them you can go to SARC or counselling. A campaign showing everybody that police acknowledge anyone could be a victim but also saying if you don't want to go to police these are the agencies. Showing we are stronger when we are working together.' (Practitioner O)

Similarly, another practitioner felt there was a need to broaden the scope and focus of campaigns:

> 'I think there could be, the police have made huge leaps forward in the way they tackle rape and sexual but it is all focused on young people and night-time economy and now moved from drink to child sexual exploitation. They don't look outside that demographic at all. So an awareness it happens to older people. When you look at advertising, ours are the same, they target young people.' (Practitioner S)

All practitioners felt it was important that the police worked with sexual violence organisations and older peoples' services in designing any campaigns and raising awareness to avoid perpetuating ageist or sexist stereotypes and to ensure campaigns were appropriate for an older audience.

Moreover, all practitioners felt there is a multi-agency responsibility and the police should work with safeguarding boards and public health to develop strategies and communication:

> 'I think there is a regional safeguarding board, but focus generally around younger people and police take that lead. So communication strategy and safeguarding board should also include older people which could feed into other groups, actions for elderly etc. All agencies, not only the police.' (Practitioner E)

Another area that practitioners felt the police could help encourage older women to come forward was to have female officers available for older women reporting rape. Practitioners felt that older women may be reluctant to disclose sexual violence, particularly where it has occurred in the context of a relationship and the initial call has been for domestic violence. Practitioners felt that, in these situations, older people may only disclose the physical abuse if the police officer was male, however they may be more likely to disclose the sexual violence if a female officer attended.

5.8 A number of gaps in current service provision were identified

All practitioners felt there were significant gaps in services for older people. Whilst all of the practitioners stated they were able to tailor their own support services to the needs of the individual, on a broader level they felt a number of gaps existed and these created the barriers and challenges described in the findings. The biggest gap identified by practitioners was the overall lack of awareness among older groups that sexual violence services can offer support to victims of all ages and the types of services they offer. All practitioners felt the responsibility for this lack of awareness was multi-faceted. An overall societal ignorance and reluctance to accept that sexual violence can be perpetrated by, and against, older people means that many older people may feel sexual violence is

a young person's problem. However, practitioners also felt they were at least partly responsible for the lack of awareness:

> 'The gap is us – women knowing where they can access emotional support. Maybe a generation thing, assuming they don't want to talk about it or them not wanting to talk about it.' (Practitioner J)

None of the age-related practitioners that were interviewed offered any specific support services for older survivors of sexual violence and none had established relationships with existing sexual violence organisations, so there were no referral pathways in existence at the time of interview.

This is compounded by a lack of campaigns by sexual violence organisations, the criminal justice system and government. Previous and existing campaigns, particularly police campaigns, have largely focused on issues relating to younger age groups - for example alcohol and rape, particularly in relation to the night time economy and sexual violence at university, and are placed in locations relevant to young people - such as toilet doors in nightclubs or universities. These campaigns typically feature younger models and often focus on sexual violence in the context of the night-time economy. As one practitioner explained:

> 'Not from us but on a more general level, campaigns and awareness raising could be targeted at the older generation. In my head I think a line has been drawn where older people are concerned and it is more about focusing on the youth.' (Practitioner M)

Practitioners felt this lack of awareness was largely down to ageist stereotypes of older people and 'real rape' myths. As Vierthaler (2008) argues, rape myths have left elders out of the image of victims of sexual violence and without an appropriate community response when they are victimised. Thus, while elder sexual assault victims may require more assistance and specialised help due to age-related disabilities and other factors, they often receive fewer services and interventions than younger victims (Vierthaler, 2008, p.307). All practitioners felt they could help address this gap and challenge some of the dominant rape myths around rape involving only young attractive women being attacked by male strangers by running some of their own campaigns and advertising materials which include images of older male and female victims. They also felt they could help to raise awareness by placing materials in locations older people may be more likely to see them, as a lot of the current focus on marketing material was aimed at younger people and typically placed in places young women would see it, for example toilet doors in pubs, bars and university buildings.

Another area where all practitioners felt there was an obvious gap they could help address was the lack of multi-agency partnerships between national and local age-related organisations, such as Age UK, and Rape Crisis centres, SARCs, and domestic violence organisations:

> 'I think gaps are probably a lack of information into services that actually support older people - we are not targeting them enough and getting where we should. As an organisation we should be going to AGE UK so women know we are here, they can get support. Raise awareness. We are great at doing it for younger people but I think we need to make sure women who are older can access services.' (Practitioner K)

Another practitioner echoed similar thoughts:

> ‘You got me thinking about Age Concern just around the corner, it should be easy for them to signpost to us but perhaps we need to go offer our services to them. We do offer outreach at university and GP services. But I wonder whether if we consider elderly people. We need to get that info out there, like an advocate would find that out. We could offer to go into community centre and counsel people if they had a room available.’ (Practitioner D)

Some practitioners mentioned the gap in relation to services for specific groups of older survivors, in particular male survivors and survivors from black or minority ethnic groups:

> ‘A large chunk of my time has been spent with black and minority ethnic women and I don’t think I saw a single BME women aged 60+ come forward. [It’s] different with BME because of cultural issues, at risk of further victimisation if were to report.’ (Practitioner B)

This was echoed by other practitioners:

> ‘Out of all these years only two Muslim people have contacted me. All the older clients have been white and heterosexual. We need to start bringing barriers down. I don’t think it will resolve itself. There are deep rooted cultural barriers. When I worked with sex offenders in Bradford, officers said they just wouldn’t ever come forward and report. They cannot.’ (Practitioner C)

Al practitioners also stressed the need for more research examining the prevalence of sexual violence against older people and the impacts of sexual violence in later life.

5.9 Views of age-related practitioners

Four practitioners working in age-related organisations were interviewed. Two were Chief Executive Officers (CEOs) of local age charities, one was CEO of a national helpline for older people and one was a director of operations for a national abuse helpline.

Table 7. ARP practitioner role and organisation type

Practitioner assigned letter	Practitioner role	Practitioner organisation
ARP A	CEO	Age-related charity
ARP B	CEO	National helpline for older people
ARP C	Director of operations	National abuse helpline
ARP D	CEO	Age-related charity

None of these practitioners had direct experience of supporting older survivors of sexual violence, however the Director of Operations said 0.42 per cent of the calls received by the national helpline had been to disclose sexual violence, although a further detailed breakdown of the number of these disclosing incidents in earlier childhood or adult life (often termed historic abuse) was not available,

but the practitioner felt 'a significant' number would be. Similarly, one practitioner said the organisation had experience of historical disclosures:

> 'Organisationally we have been informed by several clients of historical child abuse. As a charity we adhere to the wishes of the client, however where permitted contact with the Criminal Justice System is made alongside a care plan and partnership working with the appropriate agency. We do not step away from the client unless the client wishes it.' (ARP A)

None of the services offered anything specific for survivors of sexual violence, but all four said they would try to refer people to relevant services. One service already had good relationships with domestic violence organisations. However, echoing the interviews with sexual violence practitioners, age-related organisations admitted they did not have existing relationships with local Rape Crisis or other sexual violence organisations, but expressed an interest in developing these:

> 'We don't refer to rape crisis, but we would consider building partnership with other areas.' (ARP B)

Another practitioner described a similar situation:

> 'We pay full cognisance to the VWAG strategy and the contacts within it, we do not have a working partnership with any rape service'. (ARP A)

As none of the practitioners had direct experience of supporting older survivors, the interviews focused on their perceptions of barriers to older people disclosing or accessing services. All

practitioners felt there was a stigma around sexual violence in later life and there had been little effort to challenge this, as one practitioner explained:

> 'It is a taboo subject. There has always been stigma. The situation with sexual violence of older people now is similar to how it was with children three decades ago – hidden.' (ARP C)

There was a general feeling that older people are less likely to seek support for all types of abuse, particularly from formal services:

> 'Older people are less likely to engage with the statutory sector for any support regardless of subject matter. The subject of rape or abuse within this demographic is felt to be a subject not to broached therefore not reported.' (ARP D)

Consequently, it was felt that older people may be more likely to turn to informal support through family, friends or carers or charities:

> 'Older people have a distant respectful view of statutory services and hate to feel a burden therefore approaches if made at all are via support networks such as carers or charities.' (ARP D)

The key issue mentioned by all four practitioners was an overall lack of awareness of sexual violence in later life, echoing the views of sexual violence practitioners:

> ‘There are no campaigns at all around older people and sexual violence. There is no research either, certainly not in the elder abuse field anyway.’ (ARP C)

Other barriers to accessing support or disclosing abuse included: understanding of the term; clarity of who to go to and the possible follow up actions; confidence they will be listened to; fear of being dismissed; knowledge of access routes; approachability; re-victimisation.

Practitioners felt dementia was a key barrier for older people reporting any form of abuse, but particularly sexual violence because of the fear of not being believed, or confusion over what had happened:

> ‘Also where [there is] dementia, [it] might be domestic violence with a partner, but the person is scared to talk about it.’ (ARP B)

Practitioners felt further research was crucial in helping them getting funding to support vital services as well as informing support services. They felt that without the research highlighting that sexual violence happened in later life, they were unable to secure funding and resources to run campaigns or improve awareness through training in their own organisations. As one practitioner explained:

> ‘What can be done? Research, so we can say ‘it is happening’. I think there are thousands more than your research has found and there is nothing in place for them. We need more awareness, not just that it happens in domestic violence situations, but recognising all contexts.’ (ARP C)

5.10 Discussion

Overall, sexual violence practitioners had limited experience of supporting older survivors who experienced sexual violence in later life, mirroring findings in previous studies (Scriver *et al*., 2013), and none of the age-related practitioners had any direct experience of supporting older survivors. On average, sexual violence practitioners had seen no more than five survivors over this period. However, similar to the study by Scriver *et al*., practitioners said the number of people over the age of 60 accessing support for historic (typically childhood) sexual abuse was considerably higher.

The cases of sexual violence involving older people that practitioners had seen represented a range of circumstances, however a few common themes across the cases emerged: perpetrators tended to be strangers or acquaintances, similar to the findings in other studies (Ball and Fowler, 2008; Jeary, 2005) and the findings from Phase 1 of this study, and across the cases, high levels of physical violence were observed, with many of the rapes appearing to be particularly sadistic in nature, involving violence used above and beyond what was required to rape the victim. This echoes some of the early findings in previous studies (Groth, 1978; Pollack, 1988; Jeary, 2005) however, this may reflect the nature of the research sample, as previous research has shown that sexual violence which does not involve excessive violence or which is committed by a partner or family member is less likely to be reported (Bachman, 1998; Tjaden and Thoennes, 2000; Koss *et al*., 1988; Gartner and Macmillan, 1995; Hanson, Resnick, Saunders, Kilpatrick, and Best, 1999; Pino and Meier, 1999; Williams, 1984).

The primary age-specific physical impacts practitioners had observed in their experience were linked to the assault itself and included broken bones, genital trauma, bruising and internal injuries. Whilst these are sometimes seen in younger groups, practitioners felt they were more profound in older

groups, who often suffered more severe physical injuries and took longer to recover than younger groups might. Previous studies have reported older women are more likely than younger women to experience serious visible injuries (Burgess *et al.*, 2008) and significant genital trauma which takes longer to heal than in younger women (Muram *et al*., 1992; Ramin, 1997; Jones *et al*., 2009; Templeton, 2005; Morgan *et al*., 2011). A number of potential reasons for the extensive serious physical injuries were identified. First, practitioners tended to see cases which had involved excessive physical force and violence, which led to multiple injuries. Second, the age of the victim and their personal health circumstances (for example, pre-existing conditions) could exacerbate the injuries they accrued and impact on the recovery time. For practitioners, this could create difficulties in carrying out their roles, for example forensic medical examinations were more difficult to perform if women had multiple physical and/or genital injuries, both because of the discomfort caused to the survivor but also the practical difficulties of examining someone who may be unable to fully open their legs.

Furthermore, some practitioners had experience working with older survivors who had experienced a range of long-term health consequences following an assault, including strokes or heart attacks. Whilst it was not possible to say with certainty that the rape had caused the victim to subsequently have a stroke or heart attack, the practitioners felt that, at the very least, the rape was a contributing factor. The links between other forms of abuse (for example physical or emotional) in later life and increased risk of strokes or heart attacks have been highlighted in previous studies (Fisher and Regan, 2006) and one study by Burgess *et al*. (2000) reported half of victims died within a year of being raped, however the lack of longitudinal research in this area means the long-term impacts of sexual violence on older people is still not understood. Furthermore, the majority of practitioners in the present study had only worked with older survivors for short periods of time, depending on their

particular role, so were unaware of any longer-term health implications. However, practitioners described a number of ways in which these consequences created different support needs, for example older survivors requiring different multi-agency referrals and management than younger survivors: older survivors may need more support from medical professionals, social workers and adult safeguarding practitioners, for example. Further research, which examines the long-term impacts of rape or sexual assault, is necessary to fully understand the range of physical impacts on older survivors and what support needs these create.

Practitioners, particularly forensic medical examiners, felt that the negative impacts on the sexual health of older people were poorly recognised or understood. There is a distinct lack of research examining sexually transmitted diseases among older groups (with the exception of Sormanti and Shibusawa, 2008, and Sormanti, Wu, and El-Bassel, 2004). This is an important area which requires further research and should be taken into consideration by health professionals and built into support plans.

Practitioners had observed a range of negative mental health impacts on older survivors. Again, many of these are the same as those experienced by younger survivors, however practitioners felt concerned that they may be magnified for older people who were more likely to be socially isolated. Research has shown that older people, particularly women, are at an increased risk of depression. A review of literature conducted by Hybels and Blazer (2003) identified the prevalence of depression in older adults of all ethnicities and found it was higher for older women than for older men. Other conditions such as anxiety and PTSD had been observed by practitioners and again there were concerns that these may be exacerbated by age-related issues such as an increased chance of older survivors living alone, having limited social circles and family support and having other physical or

mental health issues. Again, these may create specific considerations for practitioners, for example signposting or referring older people to other services which can support them with social isolation or loneliness.

Practitioners described some coping mechanisms they observed with older survivors, which were usually linked to prescription medication, counselling and support from family and friends. However, several practitioners raised concerns about the number of older survivors abusing alcohol. This mirrors other elder and interpersonal abuse studies (for example Acierno *et al*., 2010; Anetzberger *et al*., 1994; Hwalek *et al*., 1996) which have found increased risk of alcohol or substance misuse in abused elders compared to younger groups. However, the number of cases seen by practitioners is very low and were characterised by excessive physical violence and serious health implications, which may lead to an increased risk of alcohol use than older people who experienced rape in different contexts.

Although practitioners felt older survivors faced many of the same challenges as younger people in accessing support, a number of specific challenges that older survivors can face were identified. These broadly fell into three categories: physical challenges, emotional challenges and societal challenges and these created a number of specific considerations for practitioners. In terms of physical challenges, the main issues centred around poor physical health and disabilities, which could cause problems for survivors physically accessing support services. Research has shown that disabled women (Macdowall *et al*., 2013; Khalifeh *et al*., 2013; Smith, 2008) and men (Mitra *et al*., 2016) are more likely to experience domestic or sexual and may be less likely to seek help than non-disabled women (Hague *et al*., 2008) although some research reports no difference in disclosure rates (Khalifeh *et al*., 2015). Although most of the practitioner's services were accessible for those with

physical disabilities (i.e. wheelchair accessible) and had rooms on ground floors, some of the practitioners felt their services may be difficult to access for those with complex physical health issues. However, the majority of practitioners were able to offer outreach support, using community facilities such as village halls, libraries or GP practices or, if required, in the survivor's own home. In some cases practitioners had offered support within the care home where the survivor lived. This was identified as best practice and a service that should be considered when supporting older survivors.

In terms of emotional challenges, many of these are similar to those cited among younger groups, including shame, embarrassment, and fear of not being believed (Patterson *et al*, 2009). However, practitioners felt these may be exacerbated for older people because of their age, previous experiences of trauma (which may include previous experiences of sexual violence) and a deeply embedded shame that is rooted in their generational norms and values, particularly if the sexual violence has occurred in a familial relationship. Age Practitioners also felt that older people would be more reluctant to disclose abuse and engage with services because of the stigma around sexual violence being particularly acute in older generations, who were socialised into traditional gender roles. Thus, rape stereotypes function to attribute blame to older victims, who do not fit the 'real rape' stereotype (Chapter 1.6) and society's dominant understanding of rape. Furthermore, as older survivors were socialised into traditional gender roles, before the second wave feminist movement, which drew attention to the widespread incidence of sexual violence, and before some of the key changes in legislation which improved women's rights, they may have internalised these 'real rape' stereotypes, which may be compounded by a continuing lack of recognition of sexual violence in later life. For practitioners working with male survivors, they felt this may be even more difficult because of the stigma attached to being raped by another male, or in the cases involving female perpetrators,

being embarrassed and confused about experiencing sexual assault by a woman and rape myths around real men not being raped may contribute to this (Groth and Burgess, 1980).

However, arguably the biggest age-related challenge cited by practitioners was dementia, an issue that has not received consideration in the existing sexual violence literature. This was a concern expressed by all of the practitioners who were interviewed and was multi-faceted: practitioners felt dementia could potentially leave older people more vulnerable to victimisation, particularly in the context of nursing homes or where the older person was dependent on the abuser for care, but also created challenges for practitioners supporting survivors who had dementia in terms of (1) gaining consent to perform examinations or provide supporting services and (2) the ethical difficulties that arise when supporting someone who cannot partially, or fully, remember the sexual assault. Age-related practitioners also felt dementia could be a barrier to older people reporting sexual violence or engaging with services, through confusion or the fear of not being believed.

The links between dementia and elder abuse have been documented in the existing literature – for example, some control studies have found higher levels of dementia and depression in elder abuse patients (Dyer *et al*., 2000). Concerns about whether professionals are alert to the signs of physical and sexual abuse among older people suffering with dementia have already been raised (Flannery, 2003). However, there remains a lack of contemporary research in this area, and no existing policies or best practice guidelines were in place in the practitioners' organisations. It is important that these issues are explored more thoroughly and practitioners are aware of the ethical and practical considerations when supporting a survivor with dementia. For practitioners performing medical examinations, this is particularly important in order to obtain informed consent to perform such procedures. Furthermore, there is a need for the development of policy in relation to supporting

those who have experienced rape or sexual violence but who lose some or all of the memories of this. As several participants pointed out in this research, it is counterproductive to continue to remind somebody of a traumatic event if they have no recollection of it.

Previous research has found a low rate of prosecution and convictions in cases involving older victims of sexual violence (Burgess *et al*., 2008; Ramsey-Klawsnik *et al*., 2008; Shields, Hunsaker, and Hunsaker, 2004; Teaster and Roberto, 2004a; Pinto *et al*., 2014) primarily due to insufficient evidence or inability of the older adult to report. A number of barriers to reporting to the police were identified by practitioners, who felt shame and stigma, fear of the police and negative associations with the criminal justice system may act as barriers for older people reporting sexual violence. Moreover, many of the older women who had pursued prosecutions had negative experiences either with the police or at trial stage. These issues chime with those described in the domestic violence against older women research (Scott *et al.*, 2004) and highlight a need to examine how the police and support services can minimise some of the barriers older people face.

A number of gaps in the existing services were identified. The main gap related to an overall lack of awareness in society that rape can occur in older age groups, which was multi-faceted. In part, rape myths were to blame for perpetuating the idea of the 'real rape' scenario which involves a young male stranger who attacks a young, attractive female at night. There has been a lack of attention to the age element of this myth and most research, campaigns and policies have focused narrowly on younger victim-survivors, further hiding the reality of sexual violence in later life. None of the participants' organisations had ever run specific awareness campaigns aimed at older groups and most admitted they generally advertised their services in locations where younger people would attend – for example, nightclub and university toilet doors (although advertising material was usually

available in community locations such as doctors surgeries as well). Similarly, age charities had not run any campaigns or been involved in supporting any and felt this was an obvious gap that could be addressed. Several practitioners said they were going to address this and look into running a specific campaign targeting older people and make their materials more widely available in locations where older people may be likely to attend (for example churches, libraries and most importantly, local age-related organisations such as Age UK). Practitioners also felt health and criminal justice agencies had a responsibility to produce campaigns, particularly posters, which were inclusive of older people as they commented that the existing materials, particularly police posters, were very narrowly focused on young victims and perpetrators, often linked to the night-time economy.

Both sexual violence and age practitioners also felt there existed a number of gaps in relation to services offered by support organisations; practitioners felt there should be better relationships between sexual violence organisations and age-related organisations; whilst all of the practitioners said they had existing multi-agency relationships, none had any specific links with age-related organisations and they felt this was a limitation of their current service provision. Some of the age practitioners had working relationships with domestic violence organisations but none had any direct referral pathways with sexual violence organisations. Another issue highlighted by both sexual violence and age practitioners was the lack of research in this area, which some practitioners felt was important for them to secure funding and resources to improve services in this area. Without research highlighting that sexual violence happens in later life, practitioners said they would not be able to convince funders that this was a serious problem deserving of specific training, campaigns and service delivery.

5.11 Summary

This chapter has explored the views of sexual violence practitioners on the impacts of sexual violence and challenges experienced by older sexual violence survivors, and how these affect practitioners supporting older survivors. There are a number of implications for practitioner services and a need for further research to examine the key issues of dementia, gaining informed consent and training/support for practitioners who may find it emotionally difficult to support older people. Real rape myths and stereotypes were also an issue identified by sexual-violence and age-related practitioners who felt this made it difficult for older people to recognise they were a victim of sexual violence and make a disclosure. Gaps in service provision were also highlighted by practitioners, particularly the lack of awareness campaigns and multi-agency partnerships between sexual violence and age-related organisations. However, given the small number of older survivors practitioners had worked with, and the nature of the information provided by practitioners based on opinions about the issues survivors face, it is imperative that older survivors' voices are added to this framework. The following chapter will present the findings from qualitative interviews with three female survivors who experienced rape since the age of 60.

Chapter 6: Phase 3 – Case studies of older survivors

6.1 Introduction

This chapter presents the findings from in-depth, qualitative interviews with three female survivors who experienced sexual violence since the age of 60. Only one previous study has specifically conducted interviews with survivors of sexual violence in later life (Scriver *et al*., 2013) however that study interviewed only one survivor of sexual violence in later life and the focus was on the details and background to the sexual violence and her experiences of accessing support. Although still a small sample size, this research makes an important contribution to the gap in research, in particular, the impacts, support needs, challenges and how age affects each of these areas. Adopting a case study approach and using an Interpretative Phenomenological Analysis framework (See Chapter 3.4.4) this chapter outlines in detail the experiences and views of three older survivors and concludes with a discussion of the findings in the wider context of the existing sexual violence literature. A critical examination of the theoretical implications of these findings is provided, drawing in particular on the work of Kelly and Radford (1990) to show how sexual violence is experienced on a continuum by these women across the life course, with age and gender intersecting to shape these experiences. The ways in which these women minimise their experiences of violence and the way rape myths influence the way they make sense of, and construct, their experiences is critical to understanding the narratives of these women.

6.2 Case study 1: Winnie

Winnie was in her 70s at the time of the interview and had experienced recent sexual violence in the context of a long-term relationship. She referred to a single incident of rape, which had been one of the reasons she had left her husband, however she described ongoing emotional abuse by her husband who was controlling of her and indicated she may also have experienced incidents of financial exploitation by her husband and other family members, bringing her experiences within the definition of domestic violence. At the time of the interview she was living independently in a supported housing development. She had adult children and grandchildren although she mainly kept in touch with her daughter and granddaughter who lived locally and did not have a lot of contact with her other children.

Winnie was first put in contact with a social worker through her daughter because of her relationship with her ex-husband, which caused her daughter some concerns:

> 'My daughter got in touch with them, my daughter got in touch because she saw what sort of a state I was in. I tried to pretend it wasn't happening and that everything was alright but she saw to (support worker) and (support worker) agreed to come to the house and they took me away to the welfare centre. The attendance centre. What do they call it? It was like a refuge.'

Following this, she was referred to a local domestic violence organisation who had also provided her with support getting set up in her new home, accessing benefits and legal support and advice. She also mentioned a welfare centre where she stayed briefly, although this was not exclusively for domestic violence survivors as there were also men staying there who had 'fallen on hard times'.

Winnie had been with her ex-husband for twenty years but had only been married for a relatively short time. She describes the domestic violence, which was predominantly emotional violence, getting worse once they had married and 'little things' becoming bigger issues as time went on:

> 'To say demanding is putting it rather strong. To be controlling of me. And it became more when we married. I was even criticised for the way I walked, I had difficult in walking straight and when I took his arm he complained that I was pushing him sideways. And I chose to get a stick and walk on my own. Just little things.'

It has been suggested that domestic violence in later life can take a number of formats: domestic violence 'grown-old'; domestic violence that begins in later life and domestic violence in a new relationship in later life (Ramsey-Klawsnik, 2003). Winnie's experience would appear to fall into the latter, as although she minimises the earlier abuse and describes it as worsening after marriage, she does make reference to controlling and emotionally abusive behaviour since the start of the relationship.

Winnie described herself as being a 'good wife' and this was very much linked to the generational expectations she grew up with and the gendered norms and expectations of women. To her, being a good wife was making sure she did domestic chores well and took responsibility for 'looking after' her husband:

> 'I gave him a good life, I was a good wife even before we were married, I was true to him and he was true to me and I cooked well and sewed well. I sewed his jackets, the pockets of which came through, I sewed them up. I would do anything. I would do anything. He would even

want me to wash his hair which is ridiculous when you think about it. I can't even wash my own hair.'

In terms of impacts, the sexual violence itself had not caused Winnie any long term physical problems, although she describes some bleeding initially although she said this was 'not severe enough to go to the doctors'. However, the emotional impacts from the abusive relationship had clearly had long-term consequences for Winnie and she spoke throughout the interview about her frustration and feeling upset about the way she had been treated by her ex-husband.

Winnie stated that her husband had not been sexually violent to her until the first, and last, recent rape, however she describes previous sexually controlling behaviour and sex always being on her husband's terms, particularly in relation to the time and place they would have sex. This did not seem to be something Winnie had considered abusive and she described it more in terms of it being annoying:

'Well, only in the timing of it. It wasn't allowed to be thought about at night time. You just didn't bother because you knew he wasn't interested. But apart from that nothing else, nothing else it all came about suddenly.'

Kelly and Radford (1990) argue that women frequently say 'nothing really happened' when they experience sexual violence because these experiences are deemed insignificant or less serious than rape. According to malestream ideologies, these everyday intrusions and men's controlling behaviour is minimised and normalised, therefore women have difficulties in naming these experiences as sexual violence. Instead, women will commonly play down their experiences and not

make the connections between this and the 'more serious' incidents. This is the case for Winnie, how she describes the most recent and more serious incident of sexual violence as 'different':

> 'Well, he decided that he wanted it and manhandled me so that we were into it. There was no point in me saying I didn't want to because he had to have his own way. You just did it, you just knew.'
>
> [Researcher] So no point stopping him? Why?
>
> 'Well, physically he could win.'

It is interesting that Winnie does not make the links between her husband's previous controlling behaviour and the emotional abuse she experienced, and the rape which she describes as the final incident. Instead, Winnie appears to make distinctions between and separates out these experiences. However, these experiences operate on a continuum and are not mutually exclusive (Kelly, 1988), which is exemplified by Winnie's experience of emotional and controlling behaviour. Winnie later goes on to explain that since leaving her husband, her daughter has revealed he had previously 'made a pass' at her. Reflecting on this, Winnie admitted she was 'not surprised'.

Initially, Winnie did not disclose the rape to any formal agencies or practitioners and this was mainly because she felt ashamed. This again was tied to generational norms and expectations:

'When I finally went to the police and to my doctor I was ashamed, it was something to be ashamed about. I was glad my parents weren't alive, because if they had known they would have died.'

[Researcher] What made you feel ashamed?

'Just in my upbringing. They just weren't done with violence. You just didn't believe good men were violent. You had read about it happening in film stars, people who treated their wife less than the way they should, like Alex Guinness, and that showed a lady who had suffered. I just didn't expect it to be me.'

Research has consistently found that women experience shame and self-blame across all forms of men's violence (see Chapter two) however for older women this is may be magnified because of generational norms and practices. As Kelly and Radford (1990) noted, until the feminist activism of the 1970s and 1980s, violence against women was not publicly discussed and women's experiences were ignored and their voices silenced, in part linked to the lack of naming and defining of individual behaviours which constituted abuse. Here, Winnie describes believing sexual abuse was something that happened to 'other people', highlighting the lack of awareness of how common sexual violence against women is. This has been echoed in the domestic violence literature, which has found that older people are often not aware of the commonality of abuse, or what constitutes abuse (see Chapter 2.3.1).

Winnie did decide eventually to report the rape to the police. She found the police to be supportive, although her solicitor had advised her to concentrate on the divorce as pursuing rape charges may have impacted on her divorce case:

> 'I reported about this rape. They offered to take it up but the judge, the solicitor warned that it might be deter things an awful lot. And the police said no it wouldn't so I decided it was better to have the divorce seen to and settled first and then to take up the case against him afterwards. They have been to visit him apparently and they contacted me to say they had told him about it, of course he denied it, he would deny anything. They said don't worry they have met his type before. I said OK, well he will fool you, he will fool anybody.'

Depending on the outcome of the divorce, Winnie was considering pursuing the rape case. Her main priority was getting her financial entitlement and this was stated on a number of occasions. She did not feel she wanted to continue with the rape charges 'for continuing sake' because of the potential impact on her family:

> 'If the outcome is not what I want - if the outcome is satisfactory I don't know. There is no point in continuing just for continuing sake. Punish him yes but punish myself and my family, no.'

Winnie also felt the support she received from her GP was good. She was offered counselling but declined. When asked why she had decided to go to her GP she said she went because 'everyone kept telling me I should tell my GP'.

Winnie felt it would have been easier to leave her husband if she had been younger. Age has been described as a barrier to leaving abusive relationships in the existing research (see Chapter 2), which has reported that reduced social networks, declining physical health and lack of financial independency linked to older age can make it challenging for older people to walk away. A number of reasons were cited but mainly she felt that being younger would have made her stronger, physically and mentally, and also financially independent as she could have found a job to support herself if she was younger.

Winnie had been married three times previously and had instigated the relationship ending in at least two of those relationships because of both men's anger issues and jealousy, which she felt was easier to do when she was younger. Here again the violence Winnie has experienced over her life course represents a continuum – it is clear that men's violence and control has been a feature across her relationships. This is not uncommon; recent research has highlighted that the levels of repeat victimisation are higher than the national statistics currently capture (Walby *et al*., 2014) and previous studies have found increased risk of repeat-victimisation for women who experience domestic violence (Bybee and Sullivan, 2005; Krause *et al*., 2008).

Although Winnie felt she had been well supported by the agencies she had disclosed to, she felt more could be done to support older victims of sexual violence. Winnie said that more awareness and campaigns, like the posters or stickers on toilet doors would have encouraged her to report, however she also felt that professionals (particularly solicitors) should have more understanding about domestic and sexual violence, particularly in later life:

'I don't know whether they know about it enough. Perhaps it wants enlightening. I think it would help, if you could have got a solicitor who understood it. I think the police support is strong and your support too. I think it all wants encouraging.'

6.3 Case study 2: Jennifer

Jennifer was aged 67 at the time of the interview and had experienced sexual violence on a number of occasions throughout her life, with the most recent (and the most serious) an incident of rape at the age of 64 by two men significantly younger than her. The perpetrators were known to Jennifer prior to the rape as one was an extended family member and the other was his friend. At the time of the interview Jennifer was living on her own but had a long-term partner to whom she was engaged and who was shortly moving in with her. Jennifer had a friend with her throughout the interview who had been the first person Jennifer disclosed to and a constant by her side throughout. Jennifer described how important the support of her friend had been in helping her:

'Otherwise I don't think I would be here because I couldn't report the rape after it had happened, I couldn't tell anyone and I didn't but I couldn't. I knew, I tried but I couldn't live, I couldn't carry on with what had happened to me.'

Despite knowing what had happened was wrong, like many women, Jennifer found it difficult to conceptualise or label her experience and was confused initially about what had happened:

'I felt awful and I felt terrible but I just didn't realise what had happened to me. And I didn't realise how serious it was and I knew at the time it happened, I could die here.

Jennifer described a number of negative impacts the rape had on her, physically, mentally and in terms of her relationships and lifestyle. Jennifer experienced a particularly physically violent rape, however the physical impacts were mainly short-term and had included extensive bruising and minor cuts and some vaginal trauma, although she also suffered some long-term physical health conditions from the rape, including permanent damage inside her rectum which made it painful when using the toilet. Emotionally and mentally Jennifer felt she had coped quite well although describes feelings of depression and thoughts about ending her life in the initial period after the rape. Long-term, the main lasting impacts centred on the humiliation and degradation Jennifer had experienced during the rape, partly related to the relationship with one of the perpetrators (family member) but also how he had spoken to her during the rape and the acts he had made her perform as part of the sustained attack:

> 'It is what he said and things I remember he said were 'say it, go on' he wanted me to keep saying 'I am a dirty little slut'.'

She felt fortunate to have the support of her long-term partner but said the impact on their relationship had been dreadful, as both of them had struggled to come to terms with what had happened, particularly as the perpetrator was an extended family member.

One of the perpetrators, the family member, was found guilty at trial; the other perpetrator was found not guilty. The perpetrator who was found guilty was the extended family member and was given a sentence of around 7 years. At the time of interview, he had recently been released from prison to serve his remaining sentence in the community. This worried Jennifer, although she was determined this would not stop her living her life:

'But I am not living my life in fear but I am always a bit wary and make sure my doors are locked.'

Furthermore, it had changed the way Jennifer felt about men and her relationships with them:

'It has made me think about and look at men differently, especially situations for myself and other people. It has made me not like men so much, to think that men can behave like that to women. I have probably changed my behaviour in the sense of locking my doors.'

Initially, Jennifer did not want to report to the police, however the support of her friend and local SARC were critical in her making the decision to report her experience:

'No. Because what I liked about being at the SARC, if there was anything to like about, was that they were so, so, so understanding and reassuring and they understood what had happened to me. And they said 'you don't have to report it, but if we do these tests on you now, let us do them now because now is a good time, it is not immediately after the rape but within 7 days, we can keep all that evidence for up to 15 years if you change your mind, all that DNA'. And I thought that was a sensible thing to do, because I might. But at that moment I couldn't.'

One of the main motivations for Jennifer reporting to the police was the desire to protect other women from being raped, particularly as the perpetrator had threatened he would rape the victim, and other women, again in the future:

> ‘Thinking about B and his poor wife and what he had done to me and, because he boasted that he would obviously do it again. I think, I don’t know if it was the next day or the next day. I know I went and got the photographs done on the Sunday so it must have been the Saturday or the Friday, so it wasn’t long what SARC said and me thinking.’

Her friend was also instrumental in encouraging Jennifer to report to the police and she describes her as being ‘my strength’:

> ‘I just want women to know what men can do and I want women to report them and I can’t say fight back but not to let them get away with it because the thing that went through my poor head after this happens was ‘he shouldn’t have done that, he can’t get away with that, but he will’ (Friend name) was my strength and said ‘no he can’t, he raped you!’ But I wouldn’t go to the police but she wanted to support me and she did.’

Moreover, having her experience validated by her friend and local SARC was fundamental in Jennifer deciding to report:

> ‘People I spoke to told me rape is the 2nd most serious crime to murder, I didn’t realise, I didn’t know that, I didn’t realise that and I couldn’t let him. I had to try and do something. I didn’t think I would win for one moment, not for one moment, but I knew I couldn’t sit back and do nothing.’

Jennifer spoke highly of the services she had encountered and received support from, in particular the local SARC and police. However, despite describing overall positive experiences, Jennifer had

found the process of reporting rape and being examined through to the court trial difficult in a number of ways. First, the forensic examination at the SARC had been distressing, particularly because she knew on a social level some of the people working at the SARC:

> 'And drawings of every mark on your body. That was awful. And then that was on the Thursday and then on the following Sunday [friend] took me to [the] police station because I was asked to go and have them photographed. And the policewoman who took the photographs was a friend of a friend of mine, and I had met her on a social occasion. She was a friend of an ex-boyfriend. She says 'it is alright; this is my job'. And she was a policewoman obviously. And whether she told anyone or not, she might have told one of her friends. But I hope she wouldn't have told my ex-boyfriend and his mates, that would be more than her job was worth. I had bruises around my breasts and legs.'

Jennifer credited the ISVA for their support and felt this had helped her to understand the court process and not fear giving evidence. In particular, the tour of the court room prior to the trial helped Jennifer know what to expect and feel more comfortable giving evidence and encouraged her:

> 'I had a screen. The only people who could see me was the barrister, jury and judge. I had a screen and that was because of the ISVA because the ISVA arranged through SARC me to go to (town) court and to go in a court room with a court volunteer to go through the whole process. They showed me how it was set up and showed me a TV screen on the wall and they made me realise that a person on a TV screen is not going to have as much impact to a jury than a person standing in front of them. I thought 'I want to be flesh and blood, I don't want to be on a TV screen'.'

> ‘That made a big difference to me. I had a volunteer with me and erm - and I knew from going to court to see how the process was that when I walked into court no-one would see me walk into court and no-one saw me walk out of court.’

Furthermore, the health practitioners Jennifer saw, in particular the counsellors and trauma therapists, had been very supportive to Jennifer:

> ‘She was absolutely wonderful. I used to talk to her a few times and she made all these notes and those notes were actually used at the court case, but the good thing about those notes were, and she made it clear from the start that, in no way was she able to discuss any of the details of the rape. And what happened, I used to think ‘what is the good in this if I can’t talk about it’ but we couldn’t but she was so clever, a consultant psychologist, we did and that was a support offered through the hospital because I had to go to the GUM clinic for swabs and tests.’

Jennifer received a type of trauma therapy called Eye Movement Desensitisation and Reprocessing (EMDR) which she described as being a crucial part of her recovery and one of the main reasons she was able to deliver presentations and talks about her experience and be involved in the research:

> ‘She got me to move the memory from the emotional part into one of the factual parts, so that I am able to speak to you in a factual manner and when I see men, two men in their 40s walking towards me, I don’t have a panic attack, I don’t feel dread. And she did that with several parts of the whole experience.’

Jennifer's rape had been particularly violent, involving two male perpetrators who used excessive physical and emotional violence throughout the assault which had left Jennifer with a range of long-term negative health impacts. She described feeling that she was going to die during the assault and the frustration of not reacting how she thought she would because of shock:

> I thought I was going to die. I couldn't fight back because. If you think you're going to die, you think you will fight back but I couldn't, I couldn't find back because I was in too much shock and when you suffer from shock you actually can't do anything. I was terrified.

Some practitioners had struggled with the details of Jennifer's rape when she described what happened to her. She recalls one doctor at the local hospital finding it emotionally challenging:

> 'I told the doctor what happened and the doctor cried. She was in tears and I still see her now, now and again, if I take clients to and she always comes and gives me a hug.'

Jennifer felt her age affected her experience of rape in a number of ways. In some ways, Jennifer felt it might be worse for a younger victim because of a lack of life experience and not knowing where to go for support:

> 'This is an older woman's rape, but do younger women, do they get the same experiences that I get? Do they get the control? Well they must do, it must be awful for a younger person to think that whenever you come here I am going to fuck you. Perhaps there is a lot of young

people out there who can't do anything about that and don't do anything about that who that does happen to, I don't know.'

However, in other ways she felt younger women could be more blasé about their experiences and seem less negatively impacted. She described a previous experience of sexual violence when she was a young woman where she hitchhiked a lift with a man and two of his friends, something she did frequently as a young woman. Despite the driver refusing to take Jennifer home and instead driving her to a nearby remote location, Jennifer had not considered this an incident of sexual violence, again minimising it because it did not result in rape:

'I think you think differently when you are younger. I didn't report it and I wasn't raped, I just fought him off and he took me home and I snuck in the house in my tartan jeans, ripped, and took them to dry cleaners and got them repaired without my mum knowing. He never got as far as doing anything he just got as far as trying to unzip my trousers. And he locked the doors on the car. But he took me home, he just gave up.'

Her friend agreed that those experiences were a regular occurrence when they were younger and they never felt fear that if I said no, they would carry on. Both Jennifer and her friend clearly minimise these earlier experiences of sexual violence, despite the objective seriousness of this particular example of sexual assault. Again, this highlights that women experience a continuum of sexual violence across the life course, ranging in frequency and form, but tend to invalidate those experiences which do not result in rape.

Jennifer felt this was very much related to age and the particular generation she was from, where sexual violence was accepted and was not openly discussed in society:

> 'I am of a generation of the 60s and in the 50s people definitely didn't speak of those things so society has changed and perhaps that is why we are how we are. You just didn't talk about things. So it is different to older women.'

Moreover, Jennifer felt age made people resilient to trauma and better equipped to manage negative experiences, drawing on their strength and experience of previous events:

> 'I felt at one time I could go into depression over this and end my life and get into bed and go under the duvet and stay there and not bother about anything because that was the only way out for me and I am sure this is what (friend) means, they can't cope with it. And through my age and maturity. You have been through divorce, life-threatening surgery and you have been through rape. My friend tells me God never gives you more than you can bear.'

However, one of the biggest issues for Jennifer in relation to her age was the idea that rape didn't happen to older women:

> 'At my age I should be respectable, it shouldn't happen to women at this age. I didn't think of women in their 60s as targets for rapes anyway and erm - it's just not a done thing for a woman over 60 to.'

Both Jennifer and her friend felt that their youthful looks may have made them targets. Again, associating rape with being a young, attractive woman, they felt that their efforts to 'remain young':

> (Friend) 'We have worked hard at looking young. Maybe that is something that puts you in danger, if you work hard at looking younger than you are? I don't know. Who wants to look like they are 90? Or 60?'

Although Jennifer had received support from a range of services, she had never made contact with any age-related organisations. She felt these sorts of organisations were not relevant to her:

> 'That never crossed my mind, to tell you the truth when I get correspondence from SAGA I chuck it in the bin.'

However, Jennifer had found the age, and the gender, of the practitioner was important, particularly with the police officers who had been involved in her case:

> 'The police officers, women, who interviewed me were younger than me. That was strange. The male police officer, that was different, I was a bit better with him I suppose. Although the two women were brilliant. That is just not a job I saw young girls doing so I was quite surprised at that but they were absolutely brilliant. But they say you're going to be interviewed by a PO and this little young thing comes out and you think 'God, she is a baby!' and that is the age thing again.'

Jennifer felt there should be more awareness that rape can occur across the lifespan, particularly in age-related organisations who may focus on more stereotypical aging issues and not consider the importance of including domestic and sexual violence:

> 'There is not enough. Instead of Womens Institute mornings talking about bloody flower arranging, they should talk about assault and rape, yeah, I really do. Because I am sure there would be a response.'

However, one of the reasons for the lack of awareness by some organisations may be based on austerity cuts:

> 'I don't think there are enough police to be raising campaigns, the forces have been cut so much, they rely on police volunteers to do a lot of the work that special constables should be doing but aren't doing.'

6.4 Case study 3: Mary

Mary was interviewed on my behalf by her support worker because she felt more comfortable answering questions with someone she knew and trusted. This is described in detail in Chapter 3.4.3. At the time of interview, Mary was aged 71 and living in the West of England where she had lived most of her life. She has two children and a number of grandchildren. She had been raped recently by her neighbour.

Mary reported the attack to the police around three days after it happened. She called 101 and the police came out to her home. However, she found this very difficult:

'I couldn't speak, I was too traumatised, I couldn't really tell them exactly what had happened.'

Mary felt she was treated very well by the police and found them to be supportive. She gave her details of the local SARC and advised her to go see her GP for support. At some point later, approximately six weeks, the police asked to see Mary and she was visited by a policewoman at her home around 6pm on a Saturday evening. This second experience with the police was very negative. The woman who attended her house asked Mary to pull her trousers down so she could look at her. Mary described this as a 'humiliating experience' and was unsure why she had been asked to do this.

She was referred to a local rape crisis by the local SARC, which she had attended following the assault, having presented at hospital which referred her to the SARC. Mary waited around five days to a week after the rape before attending hospital. She went to her local general hospital feeling unwell, however she was advised to go see her GP and referred to the local SARC. Mary felt quite let down by this initial experience. It was after 9pm when Mary presented at the hospital and she was sent home hours later on her own in a taxi, without any examination or further help.

The local mental health team and the SARC were much more positive experiences. Mary described these as:

'They were very helpful. Very nice people. They treated me, they sorted some tablets out for me to help me concentrate a bit more.'

Mary had found it difficult to understand the reasons behind what had happened to her. At one point in the interview, she asked 'why would a man want to attack an oldish lady?' And felt she would not be believed by people because they would not be able to understand why a man would attack an older lady. She felt she might be judged by professionals, particularly medical professionals:

> 'I think it was different – not laughing at me but thought a woman of my age, what a predicament to get into.'

Mary also described how she felt blamed by her GP, who had told her:

> 'You don't go into people who are more or less a stranger house's, so I shouldn't have gone there.'

However, despite this victim blaming, Mary did not feel responsible for her rape and did not blame herself. Again this was linked to her age:

> 'I am not exactly a young person I am not into that sort of thing, not sexually active. So I wouldn't have thought he would have bothered.'

Mary did not want to involve the courts. Although she reported to the police and the perpetrator was arrested, Mary felt the process was too stressful and she could not go through with it. She explained:

> 'I was just frightened. Frightened of everything about going to court about a case like that.'

(Researcher) 'Frightened of court room or him?'

'No, about being in the court.'

Mary did not recall being offered an ISVA. She felt her age made it more difficult to get the right support. Mary disclosed to a friend. She was invited to their house for a coffee and chat but Mary found it difficult to be in their company because she just didn't feel nice.

Mary described a number of impacts. She felt the rape had made it difficult for her to relate with family and friends. She said she wanted to hold back and felt she couldn't trust some people. She described feeling that it was 'almost the end of my life, it was horrible'. She felt it had impacted on how she communicated with people, for example her lodger. She described being cagey, whereas she used to be more open with people. She said she now felt she should be a bit quieter:

'I tend to not walk in places not sure of, stay in more than used to, relax in own home rather than chase after people for company which maybe I did.'

However, Mary did not feel these impacts were any different because of her age. She felt this would be the same if she had been younger. Mary had experienced sexual violence at a younger age and drew comparisons between the two. She felt the last time was worse because of the shock of another man touching her:

> ‘It was worse last time, I think so, last time I was shocked because no other man had touched me apart from my husband. Well I have had a few boyfriends since got divorced years ago but as got older I feel I don’t need them really, I fill my time with shopping and meetings and things.’

However, Mary did think that rape was not talked about enough and there was a lack of awareness that rape could happen to older women. She felt there should be more support but that this support should come from family and friends as well as mental health services and support workers. Mary felt it had been helpful talking about her experiences and felt this was important.

6.5 Discussion

The three survivor case studies presented here all represent sexual violence in different contexts and each woman’s experience was very individual. Winnie experienced sexual violence in the context of a relationship, which was characterised by emotional abuse and coercive control, whereas Jennifer was raped by two men significantly younger than her at a family party and Mary was raped by a neighbour. Each woman had experienced a range of impacts and challenges and these reflected their individual circumstances as well as their age. However, there are common links and experiences between and across the women’s accounts, particularly in relation to understanding and making sense of their experience, accessing and engaging with support services, informal support from friends and family, experiences of the criminal justice system and the age-related issues they encountered. These are discussed in the following sections of this chapter in relation to the existing literature and a critical feminist-gerontological perspective, drawing heavily on the work of Kelly and Radford (1990).

6.5.1 A continuum of violence across the life course

Whilst the three women had all experienced sexual violence in later life in differing circumstances, what unites them is that all three had experienced sexual violence across the life course, albeit in different ways. Jennifer recalled regular experiences when she was young of being approached by men and described one occasion where she hitch-hiked and the man actually drove her to a location against her will and sexually assaulted her. Winnie had experienced emotional, physical and sexual violence in most of her previous relationships and described her most recent husband and previous husbands as being sexually controlling and coercive. Mary had experienced serious sexual assault in earlier adult life. Kelly (1988) introduced the idea of the continuum of violence. According to this concept, women experience violence across their life course, ranging from everyday intrusions into their space through to incidents of serious sexual assault and rape. Rather than separating these experiences and viewing them as distinct, Kelly argued that they should be viewed as a series of elements or events that are linked. Furthermore, instead of viewing sexual violence on a hierarchy, the interlinked experiences of harassment, violence and assaults should be acknowledged. In the accounts the women gave in this study, it is evident that the concept of the continuum of violence can be applied to their experiences of male violence.

6.5.2 Minimisation of their experiences

None of the three women explicitly made the links between these experiences and in fact the previous incidents were played down, or minimised by two of the women. This is unsurprising, given that these women were socialised into a patriarchal culture where women's roles, rights and expectations were defined by men. These women grew up in a time where rape in marriage was

immune to criminal liability, women could not get a mortgage in their own right, abortion was illegal; traditional gender arrangements, beliefs, and behaviours reinforced women's sexual subordination to men. As Kelly and Radford (1990, p.41) point out:

> 'it is only the extreme forms of sexual violence which constrain[s] and construct[s] the framework through which women have to make sense of events'.

As such, the everyday, mundane and commonplace intrusions (Kelly, 1988) were not viewed as sexual violence by the malestream, who have a vested interest in denying, minimising and legitimising those behaviours (Romito, 2008). Several researchers have argued that women's descriptions and experiences of rape are constrained by dominant discourses that act to reinforce gendered power relations (e.g. Gavey, 1992, 2005; Weiss, 2009; Womersley and Maw, 2009).

It is common for women to minimise their experiences and say that 'nothing really happened' because the incidents of sexual violence were not at the extreme end of sexual assault or rape (Kelly and Radford, 1990). Both Jennifer and Winnie minimised and normalised their earlier experiences of violence, in Jennifer's case contrasting her earlier experiences to more severe (i.e. rape). Winnie said her ex-husband had not been previously sexually violent but then went on to describe how he would dictate when they had sex and would be controlling sexually. Jennifer revealed how, when she was younger, she would regularly experience sexual advances which she felt were harmful. On one occasion, she describes what is, arguably, a serious sexual assault involving a man she hitchhiked with. He refused to take her home, tried to force himself on her and ripped her clothing. Despite this, she does not view this as an incident of sexual violence; both her, and her friend who was with her during the interview, felt these were just the sort of everyday experiences that young women

faced, and felt they were harmless. In this way, they justified these incidents as just something men did, and women accepted, echoing findings in research with younger women (Jeffrey and Barata, 2016). However, it is deeply concerning that this level of sexual violence is not viewed as serious, or labelled as sexual assault. Research has consistently found that women are less likely to label or recognise their experiences as rape (Kahn *et al*., 2003; Littleton, Axsom, Radecki Breitkopf, and Berenson, 2006; Fisher, Daigle, Cullen, and Turner, 2003), particularly where the perpetrator is a partner (Jeffrey and Barata, 2016), however it may be that older women are even less likely to view their experiences as sexually violent because of the traditional gender norms and roles which shaped their socialisation.

As Kelly and Radford argue, unless the experience of violence means the 'extreme' end of the spectrum, namely rape, women have been conditioned by the patriarchy to view these as irrelevant. Moreover, the systemic and systematic invalidation (Salter, 2012) of the reality of violence experienced by women in society conditions women to minimise their experiences. For older women this may be more deeply engrained because of their upbringings before the second wave women's movement and activism of the 1970s, which have not only challenged malestream ideologies but raised awareness of the prevalence of sexual violence in its many different forms. As such, both gender and age are important in understanding the way older women construct their experiences and how these may often occur across the life course.

6.5.3 Real rape myths underpinned how women made sense of their experiences

The way women make sense and understand their experiences of sexual violence are socially learned and culturally supported. One of the primary ways this operates is through rape myths. These myths have also been described as "practical ideologies" (Lea and Auburn, 2001) and represent the way that:

> 'society constructs a set of cultural beliefs around sexual assault, by assuming that certain settings and types of behaviour, and a particular manner of self-presentation, are precursors to rape' (Bletzer and Koss, 2006, p.114).

Such beliefs about these stereotypes are prevalent across society and may be particularly endorsed among older populations (Kalra *et al*., 1998).

For the three women in this study, belief in the 'real rape' stereotype impacted on the way they constructed their experiences and made sense of what had happened to them. Jennifer described feeling ashamed, linked to self-blame and her belief that 'at her age' she should have known better and not being so naïve as to put herself in 'vulnerable' situations. Both Jennifer and Mary described being shocked that men would want to rape them 'at their age'. These women's understandings of rape and their own experience are rooted in the cultural ideology and representations of rape victims being young. Jennifer, in particular, struggled to understand why she had been victimised and made reference to her efforts to keep herself 'looking young' as a possible reason for why she would be raped at her age. Winnie described feeling shocked and ashamed as she thought rape only happened to celebrities – specifically, young celebrities.

Previous research has found women who have high rates of acceptance of rape myths may be less likely to disclose or to experience self-blame or shame (Heath *et al*., 2011) and the accounts provided by the older women in this study are consistent with those findings. The women had internalised the myth that rape only happens to younger women and this created difficulties for them in coming to terms with, and making sense of, their experiences.

Furthermore, all described some shame or embarrassment because of their age. Shame and stigma are experienced by rape survivors across all age groups, however research with older domestic violence survivors has found this may be magnified for those in older age groups because of generational norms and values, which have traditionally silenced domestic and sexual violence survivors, and considered these matters to be dealt with privately (Scott *et al*., 2004; Straka and Montminy, 2006; Lazenbatt *et al*., 2010). Winnie explicitly mentioned being grateful her parents were not alive because of the shame she felt. Mary described feeling embarrassed that someone would rape her at her age, particularly as she was not sexually active. Arguably, ageist attitudes around sexuality contribute to such understandings. Society tends to view older people as asexual, largely based on ageist attitudes, which view old age as a process of decay, decline and deterioration (Jones and Powell, 2006). Sexuality in old age continues to be a taboo subject in society, and the existing academic literature has predominantly focused on sexual health and physiological issues in older age (Kleinplatz, 2008) giving the impression that sex in later life is either non-existent or associated with negative issues. As several researchers have noted, older people are routinely viewed as asexual and undesirable (Calasanti and Slevin 2001; Gott and Hinchliff 2003) despite research demonstrating sexual activity continues into later life (Lindau *et al*., 2007; Beckman *et al*., 2008). Women, in

particular, are depicted as either unsexy, 'frigid' or as 'cougars', a term used as a 'pejorative that reinforces age and gender stereotypes' (Montemurro and Siefken 2014: 35).

Existing rape myths contribute to the meaning victims attach to their sexual victimization. Adamant refusal to accept these myths may help victims to assign their own meaning to the experience instead of society's stereotypical ideas regarding rape (Fanflik, 2007).

6.5.4 Impacts

All three women described a number of physical, emotional and societal impacts, many of which reflect those experienced by younger women, for example physical injuries sustained during the rape (some of which were long-term), shock and trauma, PTSD, problems sleeping and negative impacts on close relationships, however the age of the survivors also created a number of specific issues. For Winnie, the only impact the rape itself had on her was some initial bleeding. However, it was clear throughout the interview that the emotional abuse she had experienced in her relationship was more significant for her and had left her feeling confused and upset. Research has shown that women often cite emotional abuse as being as bad as or worse than physical or sexual abuse (Follingstad *et al*., 1990; Walker, 1984) and this appeared to be the case for Winnie. This may reflect the fact that the emotional abuse was long-term, whereas she said there had only been one, recent experience of sexual violence in her relationship which occurred shortly before she left her husband (although this may be due to minimisation of his previous coercive sexual behaviour, as discussed above). Mary experienced some physical pain following her rape however this appeared to be short-term and she did not place much emphasis on this.

The main impacts Mary described were psychological; feeling traumatised, unable to concentrate, and confusion. This also impacted on her relationships as she felt the rape had made it difficult for her to relate with family and friends and made her less trusting of people, describing herself as more 'cagey'. Similarly, Jennifer cited a range of negative impacts on her relationships, most notably with her partner, and felt the rape had made her look at men differently and not trust them. Jennifer also experienced a range of physical and mental health consequences. The significant physical violence used during Jennifer's rape left her with a number of long term aches and pains, as well as genital trauma and long-term bowel problems. She had also experienced anxiety and depression although she had therapy for these, which she felt had been really helpful in addressing those impacts. Whilst these impacts are described across the sexual violence literature (Chen *et al*., 2010; Machado *et al*., 2011; Westmarland *et al*., 2012) and are not unique to specific age groups, they may be enhanced or magnified for older people who may have pre-existing health conditions or overall declining health linked to age.

6.5.5 Experiences of/range of support services

All three women had been in contact with, and received support from, a number of services, including GPs, Rape Crisis and/or SARCs, and the police and reported different experiences. On the whole, the survivors had positive encounters with the services they engaged with, however there were some reports of negative or distressing experiences. All three women had disclosed to their GP. Both Winnie and Jennifer felt their GP had been supportive and offered referrals to relevant services, such as counselling, however Mary felt her GP had been unsupportive and had blamed Mary for the rape, a finding also reported in the literature exploring domestic violence against older women (Pritchard, 2000). She felt she was being judged by medical professionals and this clearly had a detrimental

effect on her wellbeing following the rape. The negative effects of being treated insensitively by support services has been described as a form of secondary traumatisation or 'second rape' (Campbell and Raja, 1999; Campbell *et al*., 2001). She also felt let down by her experience at A and E where she presented a few days after the rape because of pain and feeling unwell. After a long wait she was discharged and told to go to her GP. This was late at night and she had to get a taxi back alone which she described as distressing.

Two of the women had received counselling or mental health services from local hospitals or mental health teams. The range of services the women had been involved with in part reflected the context of their experiences. Winnie, who experienced one incident of rape in the context of an emotionally abusive relationship felt she did not want or need counselling or other services and had only disclosed the rape to her GP because 'other people' had advised her to do so. However, Jennifer and Mary who were both raped by acquaintances had received support from mental health services and both described these as critical in their recovery. For Jennifer, she had received a particular therapy called Eye Movement Desensitisation and Reprocessing (EMDR) as well as cognitive behaviour therapy (CBT) to treat her for Post-Traumatic Stress Disorder (PTSD), which she experienced as a consequence of the rape. She spoke particularly highly of the EMDR therapy and felt this had helped her compartmentalise her experience and enabled her to speak about it to people without it triggering her PTSD symptoms. EMDR is recognised as an efficacious treatment for PTSD in rape (Rothbaum, Astin and Marsteller, 2005) and domestic violence victims (Tarquinio *et al*., 2012) with up to 75 per cent of patients no longer meeting the criteria for PTSD following treatment (Rothbaum, Astin and Marsteller, 2005).

All three survivors had received support from one or more specialist sexual violence service (either Rape Crisis or SARCs) and all spoke positively about their experiences. For two of the survivors, they had been referred by another service (for example hospital, GP or the police) however, in Jennifer's case she had self-referred after her friend found details of the service having searched for local services on the internet.

Interestingly, none of the three survivors had contacted any age-related organisations, whilst Winnie and Mary simply had not felt they wanted or needed to contact those organisations, Jennifer actively distanced herself from age-related organisations as she did not feel they represented her and emphasised her invested time and energy in looking younger.

6.5.6 Support from friends and family

The importance of supportive, positive reactions to disclosure of rape on the psychological wellbeing of victims has been well documented (Borja, Callahan and Long, 2006; Brewin, Andrews, and Valentine, 2000; Ozer *et al*., 2003; Ruch and Chandler, 1983) including feeling believed, having their experiences and feelings validated and reducing self-blame and shame. Conversely, negative reactions from informal networks, either overt (blaming or doubting victims) or unintentional (discouraging disclosure, patronising the victim) have damaging consequences for victims, including silencing them (Ahrens, 2006) encouraging negative feelings such as self-blame, shame, and an increased likelihood of experiencing depression or PTSD.

It is estimated that anywhere from one-quarter to three-quarters of survivors receive negative social reactions from at least one member of their informal support network (Campbell *et al*, 2001; Golding

et al., 1989; Filipas and Ullman, 2001). Being believed is one of the most important responses cited by survivors and this was of great importance to the survivors in this study. All three women had disclosed the violence to both formal and informal agencies, consistent with previous research findings. All three women had received positive responses from the people they disclosed to, although Mary had limited the details she disclosed to her friend because she felt uncomfortable doing so and it was not clear whether this discomfort was directly or indirectly caused by the friend she disclosed to. In contrast, Jennifer and Winnie felt the support of their family and friends had been crucial to their recovery following the rape. Jennifer had found her friend, who she first disclosed to, a constant source of support throughout the process and credited her with helping to get through, particularly in the early days. For Winnie, the support of her daughter and granddaughter in leaving her abusive relationship had been critical. In both cases, this support was ongoing at the time of the interview.

6.5.7 Experiences of Criminal Justice System

All three women had reported the rape to the police but had very different experiences. Winnie had found the police to be supportive, had taken her seriously and had been keen to pursue an investigation. However, based on advice from her solicitor that this may complicate her divorce proceedings, Winnie had decided not to continue with the police case at that time. It is not clear why Winnie had been given this advice and it is concerning that, as it would appear, her solicitor had discouraged her from continuing with the criminal case against her ex-husband. This unfortunately is not uncommon; research has found that many victims across all age groups report law enforcement or personnel actively discourage them from reporting or proceeding with rape cases (Campbell *et al*, 2005, 2006; Campbell and Raja, 2005; Filipas and Ullman, 2001). However, aside from the solicitor,

Winnie was happy with the support she had been given by the police. Winnie had not ruled out continuing with the police case at a later stage but felt there was no point in doing this 'for continuing sake' and would only do this if she felt the outcome of her divorce was not satisfactory. This reflects research examining reporting decisions for older women experiencing domestic violence (Beaulaurier *et al*., 2007). However, Winnie had the support of her daughter and granddaughter in both the divorce and rape proceedings.

Jennifer was also very happy with the support she had received from the police. The support of her friend and the SARC were instrumental in her deciding to report the rape, but one of the primary motivations was to prevent the perpetrators from doing this to another woman. This was particularly important to Jennifer as one of the perpetrators had bragged about his ability to rape women, referring to it as a 'numbers game', and had threatened to rape Jennifer again in the future. This motivation for reporting is similar to what other women say about their reasons for reporting rape or domestic violence to the police; Westmarland (2012) found the primary reason for women in her study across the North East saying they would report rape (whether by a stranger or someone known to them) was to protect other women and Heath *et al*. (2011) have similarly reported that a major motivation for reporting sexual violence was to protect future assaults for other women.

Mary had an initially positive experience with the police when she reported the rape however her second involvement with the police at a later date was very negative and Mary felt she had been humiliated and blamed by the officers involved in her case. One of the examples Mary gave was where one of the police officers (female) visited her house and asked her to undress so they could examine her. This is clearly not part of routine investigation or best practice and this had been flagged up by her support worker at Rape Crisis as a violation and was being investigated. The impacts on

the psychological health of victims who experience secondary victimisation by the police have been well documented and included feeling bad about themselves, depressed, violated and reluctant to seek further help (Campbell *et al*, 2005; Campbell and Raja, 2005). Mary felt embarrassed and humiliated by her experience with the second officer and decided she did not want to continue with the case after she had reported as she did not want to go through a trial, thus resulting in a silencing function (Ahrens, 2006). Despite all three women reporting the rape to the police, only one had been prosecuted at the time of the interview.

Winnie and Mary had decided not to continue with their rape cases for different reasons. For Winnie, this was based on her divorce case whereas Mary felt too frightened. Neither woman could recall being offered an ISVA or IDVA. In contrast, Jennifer had been through the trial and one of her perpetrators was found guilty and given a prison sentence. Jennifer was offered an ISVA who she credited with helping her through the process and being key to her feeling able to face the trial. The importance of the ISVA role in supporting sexual violence victims before, during and after the criminal justice process has been highlighted in recent research (Stern, 2010; Hester and Lilley, 2015) and it is concerning that neither Winnie or Mary recall being offered an ISVA, although this is not necessarily unusual, as many rape victim-survivors do not have access to ISVA services (Hester and Lilley, 2015). However, this may have affected Mary and Winnie's decision to withdraw from the criminal justice system.

Jennifer reported her experience of the trial was difficult and she had chosen not to be present for the jury verdict because she found it too hard. However, although a couple of examples were given where the defence barrister had attempted to malign and degrade her (for example, asking her to demonstrate the position she was raped in on all fours) these had been quickly addressed by the

judge. The support of the ISVA, which included a tour of the court prior to the trial, and the special measures that were put in place (for example, her police interview being used as evidence in chief and the use of a screen for cross-examination preventing the defendant or members of the public gallery from seeing her) were all important for Jennifer in enabling her to give evidence.

6.5.8 Age-related issues

All three survivors felt that age impacted on their experiences in a number of ways, particularly in terms of awareness. All three agreed there was not enough awareness that rape can occur in later life. Research examining older survivors of domestic violence has drawn the same conclusions; there is an overall lack of awareness of abuse in later life and a lack of awareness of the service available to those who are victims (Beaulaurier *et al*., 2007; McGarry *et al*., 2011). Research has consistently shown that younger women are more at risk of experiencing domestic and sexual violence and this may in part explain why there has been less attention paid to older victims. However, stereotypes around what constitutes 'real rape' and therefore 'real victims' (Chapter 8) may also be responsible for the lack of awareness or acceptance that older people experience sexual violence.

Winnie felt that her age might have been a barrier to her leaving her ex-husband sooner. She felt it may have been easier if she was younger because she could have supported herself financially by getting a job. Furthermore, in terms of the rape itself, she felt that she may have been able to prevent the rape if she was younger and physically stronger. Studies exploring the barriers older victims of domestic violence face have cited similar issues, particularly financial barriers (Zink *et al*., 2003; Scott *et al*., 2004).

In terms of understanding and recovering from the rape, Jennifer felt that it may be harder for older women in some ways, and easier in others. She felt that younger women she encountered through her voluntary work at the SARC were more blasé about their experiences and seemed less affected. However, Jennifer also described a sense of resilience associated with age, based on life experiences (in particular previous experiences of trauma such as death or war) which may make it easier for older women to come to terms with, and to an extent move on from, sexual violence. This echoes the views of practitioners (Chapter 9), many of whom felt older women were more equipped and able to deal with sexual violence than younger people because of maturity and life experiences. This has not been reported in the existing literature and warrants further research to understand how older survivors recover from sexual violence.

6.6 Summary

This chapter presented the findings from qualitative interviews with three female survivors who were raped since the age of 60. Adopting a case-study approach and interpretative phenomenological analysis, this final phase of empirical research examined the experiences of these three women, with particular focus on the impacts and effects rape had on their lives and whether age shaped these, their experiences of accessing support services and the criminal justice system, the support needs they had and how age affected these needs. The experiences of these women were discussed in relation to the existing sexual violence research and links were drawn between these findings and those reported elsewhere. The sexual violence the women had experienced across their life demonstrates the continuum that operates in relation to frequency and forms of sexual violence. This research highlights the need to include older survivors' experiences in sexual violence research to understand their needs, some of which are different to those of younger populations. The

following chapter discusses the findings from all three phases of data collection and considers the ramifications of the findings for future research, practice and policy.

Chapter 7: Conclusions

7.1 Introduction

Sexual violence against older people has received very little attention internationally. In the UK there have only been three previous studies in the last decade (Ball and Fowler, 2008; Jeary, 2005; Lea *et al.,* 2011), and one study in Ireland (Scriver *et al*., 2013). Despite significant research examining the extent, nature and impacts of sexual violence, the majority of this attention has been on younger populations, namely those aged between 16 and 30. In England and Wales, the age-cap of 59 imposed on the intimate violence module in the Crime Survey for England and Wales, which collects data on domestic and sexual victimisation, has resulted in a total lack of national data on the prevalence of sexual violence among those aged 60 and over. Moreover, although different forms of abuse against older people (elder abuse and domestic violence against older women) have received growing interest, particularly over the last two decades, sexual violence has either been excluded from the definitions in these studies or the focus has been on other forms of abuse, with sexual violence often considered a subset of physical abuse. As a result, very little has previously been known about the extent and nature of sexual violence against older people and even less about the impacts and support needs of survivors who experience sexual violence in later life.

Importantly, the lack of feminist research in this area means current understandings of sexual violence against older women have emerged from a gerontological perspective, which often views abuse as gender-neutral (Penhale, 2003), despite research consistently confirming older women are

significantly more at risk of experiencing all forms of abuse, and men are overwhelmingly the perpetrators (O'Keeffe *et al*., 2007; Naughton *et al*., 2010). This doctoral research has sought to address these gaps and contribute to understandings of sexual violence against older women, specifically: the extent and nature of recorded rape and sexual assault by penetration offences in the UK involving a victim aged 60 or older, and the impacts, challenges and support needs of older survivors. This research sought to explore how competent current support services (both sexual violence and age-related) feel in responding to the needs of older survivors. Adopting a mixed-method approach and utilising innovative methods, namely Freedom of Information requests, this research contributes to three existing fields of literature: sexual violence; domestic violence; and elder abuse.

In this final chapter, the main findings from the three phases of empirical research are summarised and discussed in relation to the research objectives which framed the study. As Bryman (2008) has noted, some researchers have had a tendency to not fully integrate the quantitative and qualitative components, but rather present the findings as if the two components are distinct. Therefore, the findings from Phase 1 (FOI requests to police forces) Phase 2 (interviews with sexual violence and age-related organisations) and Phase 3 (interviews with survivors who had experienced sexual violence in later life) are discussed together in relation to the research objectives, highlighting the overlaps and differences in the findings from each phase. Priorities for future research and implications for policy and practice are outlined. The key contributions to knowledge are discussed and the chapter closes with reflections on the research journey.

7.2 The extent and nature of police reported and recorded sexual violence against older people in the UK (Research Objectives 1 and 2)

7.2.1 Summary of the findings

- There were 655 rape and sexual assault by penetration offences involving a victim aged 60 or over recorded across the 45 police forces between 1st January 2009 and 31st December 2013, representing 0.75 per cent of the total offences across all age groups.
- The vast majority of victims were female (92 per cent); just seven per cent of cases involved a male victim. Overall, 98 per cent of perpetrators were male.
- The majority of victims were aged 60-69, though the ages ranged from 60 to over 100. Perpetrators were generally younger than victims; 66 per cent were aged under 60.
- The ethnicity of victims and perpetrators was not known or the data was missing in a significant number of cases, however where the data was available the vast majority of victims and perpetrators were white.
- The majority of offences took place in the victim's home (54 per cent) however the second most common location was a care/nursing home.
- Most of the perpetrators were known to the victim; 26 per cent were 'acquaintances' whilst 20 per cent were partners/husbands. However, 20 per cent of cases were stranger rapes.
- The links between the rape and other offences were not always clear as in a significant number of cases the data was not available or was not known, however in 51 cases the rape was linked to another offence.
- In the majority of cases it was not known whether the perpetrator was a serial offender, however in 14 cases the offender was a known serial offender.

Using Freedom of Information requests sent to all police forces in the UK, with a response of 45 out of 46 forces, the research collected data on recorded rape and sexual assault by penetration offences

reported between 1st January 2009 and 31st December 2013 involving a victim aged 60 or over at the time of the offence. The overall number was lower than reported previously (Ball and Fowler, 2008) however this study had a narrower focus on just two sexual offences, whereas Ball and Fowler examined all sexual offences. Whilst the figure reported here is low, it does challenge the 'real rape' stereotypes that depict rape to exclusively involve a young victim and highlights that rape happens across the lifespan.

The age of perpetrators was a significant finding. The national data on younger survivors (aged under 59) reports perpetrators to be slightly older than victims. Although the age differences were not as marked as observed in previous studies (Groth, 1978; Pollock, 1988) it is still a notable and more up to date finding.

The location of rapes was also an important finding, in particular that care/nursing homes were the second most common location. The majority of crime victimisation and sexual violence research excludes people living in institutions (hospitals, care homes and prisons) thus the prevalence in these contexts is not known. This finding highlights that sexual violence occurs in such institutions, in contrast to an earlier study by Ball and Fowler (2008) and raises questions and implications for future research, policy and practice.

7.2.2 Priorities for future research

There is a need for future research to examine other sources of data, in particular adult safeguarding and health data to develop a more reliable picture. This research was limited as it relied on police recorded data. It is widely acknowledged that rape and sexual assault are among the most

underreported offences, which is exemplified by the disparity between national police recorded data and the figures from the CSEW. Moreover, previous research suggests older women may be less likely to report interpersonal offences to the police than younger victims (Blood, 2004; Pillemer and Finkelhor, 1988; Rennison and Rand, 2003). The figures reported in this study are significantly lower than the number of referrals made to other formal agencies, in particular Adult Safeguarding (HSCIC, 2014).

There is also a need for research which examines a wider spectrum of sexual offences against older people in order to examine both the extent of these offences but also to compare this to offences committed against younger victims. The present research has focused only on two offences thus the extent of other sexual offences remains unknown and as the findings differ in a number of respects from Ball and Fowler's (2008) study, a more comprehensive examination of prevalence and characteristics across all sexual offences is required.

Research could also consider a wider geographical region. Data in this study was not obtained from Scotland, therefore there is currently no published research examining the extent of sexual violence against older people in Scotland, which is an area for future research.

This research utilised an innovative research method, Freedom of Information (FOI) requests, to gather national data. FOI requests are under-utilised by social researchers and no published sexual violence research, which used this method, were found. The method produced a 93 per cent success rate and it is argued in Chapter 3 that this tool should be used in future research examining sexual violence, and may be particularly useful in mixed-methods projects as the data gained through FOI requests can inform and shape qualitative interview schedules. Moreover, for research involving

marginalised or minority groups, often described as 'hard to reach' participants, interviews may not be feasible and FOI requests provide the opportunity to gain information on the victimisation of these groups.

The nature of reported sexual offences share some similarities, but also some differences, with current understandings of sexual violence against younger people. However, as others have pointed out, it is not possible to draw conclusions on the cause and effect of certain victim characteristics with risk of victimisation with such small samples (Cannell *et al*, 2014) and therefore further research utilising nationally representative samples of older adults large enough to assess factors correlated with sexual violence in later life is needed (Cannell *et al*., 2014). In particular, there is a need for future research, which examines sexual violence in care homes; most existing research, including national victimisation surveys, excludes participants who are living in care/nursing homes or are in hospital, so very little is known about the prevalence, nature and risk factors associated with sexual violence in care homes. The present study found care homes to be the second most common location where offences occurred, highlighting the importance for future research to examine this.

Whilst the characteristics of perpetrators were examined in this study, very little is known about the backgrounds or previous convictions of perpetrators of sexual violence against older people. There is a need for research which specifically explores these issues, particularly as this study found perpetrators were generally younger than victims, with some perpetrators more than 30 years younger. Understanding backgrounds and motivations is important in order to develop preventions initiatives. Very little is known about perpetrator motivations, as there have been few studies since the 1980s which have directly involved perpetrators, and this is an important gap in which requires examination.

7.2.3 Implications for policy and practice

At a policy and practice level, this research has a number of implications. Overall, the low numbers reporting to the police and accessing sexual violence organisations compared to other services such as adult safeguarding suggests a need for the police and sexual violence organisations to work closely with APS (see Chapter 2) to understand the issues and ensure there are clear referral pathways. In particular, it is concerning that the number of referrals to safeguarding for suspected elder abuse is so much higher than the police reported figures, suggesting many of these suspected cases are not being reported to the police, despite policy and legislation including the Care Act 2014 requiring adult safeguarding social workers to report to the police where a criminal offence is suspected to have taken place. As others have suggested (Brandl and Horan, 2002; Jeary, 2005), it may be that the tendency to view violence against older women as a health issue which can lead to inconsistent and inappropriate support being offered.

There are implications for people working in care or nursing homes, given that care homes were the second most common location for reported offences. The findings suggest many of the perpetrators of care home sexual violence are 'acquaintances' as well as carers, which may mean other residents or people working in other capacities. It is crucial that practitioners are alert to the signs of sexual violence and there are clear policies for safeguarding older people. This may be complicated, particularly where older people develop intimate relationships with other residents in care homes, and staff have to manage respect for privacy with safeguarding from potential sexual violence. Training could incorporate case studies, and there is a clear need for policies on responding to sexual

violence. There are also opportunities for care organisations and sexual violence organisations to work together in developing training and ensuring there are clear referral pathways.

Furthermore, the findings have implications for sexual violence organisations. From interviews with sexual violence practitioners in Phase 2 of the research it would appear very few older survivors are accessing their services and practitioners expressed surprise at the number reporting to the police. Moreover, the two main national helplines for older people (Age UK and The Silver Line) received no calls between 2009 and 2013 reporting sexual violence and the Action on Elder Abuse helpline disclosed less than 0.5% of their calls over that period were linked to sexual abuse. Therefore, it would appear older survivors are more likely to report to the police than to disclose to specialist sexual violence or age-related organisations. The reasons why survivors are not accessing sexual violence services requires further examination.

There are a number of policy implications. One of the major limitations of the CSEW is the upper age limit of 59 imposed on the intimate violence module, which collects data on domestic and sexual victimisation. As a result, there is no available data on national prevalence. This research has demonstrated older people are victims of sexual offences, however given the limitations of the data source (police recorded data) there is a need to examine prevalence through self-completion surveys such as the CSEW. The cap, which is justified on the grounds of ageist assumptions and stereotypes (Walby and Allen, 2004) should be reassessed. Moreover, one of the arguments made in favour of the cap was that a specific survey which examines abuse against older people would be better placed to collect data on prevalence (Walby and Allen, 2004) however, to date such a survey has not been conducted.

7.3 Older women's experience of sexual violence in later life: impacts, challenges and the intersections of gender and age (Research Objective 3)

7.3.1 Summary of the findings

- Older women experience a continuum of sexual violence across the life-course.
- 'Real rape' stereotypes were internalised by all of the women and this created a number of difficulties in terms of labelling their experiences and making sense of what had happened to them, leading to feelings of self-blame, shame and embarrassment.
- Age and gender intersect to create barriers in accessing support, specifically knowing where to get help and support and what services are available to them.
- The older women embodied malestream definitions and constructions of violence and minimised their own experiences of rape and sexual assault.
- The women described a range of physical and mental health impacts which may be exacerbated or magnified because of age.

Qualitative interviews with three women who had experienced sexual violence in later life were conducted (Phase 3) adopting a case study approach to explore the individual experiences of the women. Interviews explored the short and long-term impacts of sexual violence, the barriers to reporting or disclosing to the police or support services, what support they felt they needed and whether they felt age affected their experiences.

All three women had experienced multiple forms and incidents of sexual violence across their life course, demonstrating Kelly's (1988) continuum of sexual violence. However, traditional patriarchal norms, gender roles and malestream constructions of violence meant the women were reluctant to

view, or label, their experiences as sexual violence, even where the incidents involved serious sexual assault. There was a feeling that these were things to expect, particularly in younger life, and the women had internalised these heteronormative scripts which normalised sexual violence. Furthermore, the 'real rape' stereotypes were deeply engrained and this created difficulties for the women in making sense of their experiences. The women wondered why they would be victimised 'at their age' and tended to blame themselves, with one of the women actually associating her efforts to look young as making her partly responsible for being raped.

All three of the women described a range of physical and mental health consequences following being raped, including genital trauma, pain, bruising, depression, confusion, nervousness and anxiety. They perceived their age, the lack of awareness of sexual violence in later life, shame and embarrassment as challenges for older women in accessing support services or reporting to the police.

7.3.2 Priorities for future research

Although significant efforts were made to recruit a larger sample of older survivors for Phase 3 of the study, the total number was small (n=3). The issues in recruiting older women into this research have been highlighted in previous research (e.g. Roger *et al*., 2015) and are described in Chapter 5. Future research should seek to engage older women (and men) using a wider range of mediums; for example, through care homes, or adult safeguarding/social services who may have more frequent contact with older people.

The experiences of older women from minority backgrounds, for example those from black and minority ethnic groups, those in the travelling community, and men, are underrepresented in this

study. However, practitioners interviewed in Phase 2 had seen very few survivors from BME and travelling communities and only two practitioners offered services to both men and women, highlighting the small numbers of these populations engaging with support services. There is a need for research which specifically examines the experiences, impacts and challenges faced by older survivors in these groups.

7.3.3 Implications for policy and practice

The impacts and challenges practitioners had observed in the older survivors they had supported and accounts provided by the three women interview in Phase 3 give rise to a number of implications for those working in sexual violence, and health and social care organisations.

The impacts on older people may differ from those experienced by younger groups, for example exacerbating existing physical health problems such as arthritis, which may in turn make it difficult to access support services (in particular forensic medical examinations). The emotional and lifestyle impacts may also be influenced or shaped by generational norms and values; older people are more likely to come from generations where issues such as sex, abuse and rape were not discussed and women's roles were much more family orientated. In particular, older women will have grown up prior to the changes in legislation incorporating marital rape into definitions of rape, and this may heighten the emotional impacts of sexual violence, such as anxiety or depression. Similarly, these impacts may be affected by underlying conditions such as dementia. Training on how to support older people in SARCs and the Rape Crisis organisation, which factor in these impacts, and how to manage these would be useful to ensure practitioners are confident in supporting older survivors. Some domestic violence organisations have recognised the different experiences and needs of older

women and have developed specific services for older people, for example a refuge was opened by EVA Women's Aid in Redcar in 2015 for women aged 45 and older, and Solace Women's Aid in London run The Silver Project for women aged 55 and over who have experienced domestic and/or sexual violence. However, there remains a dearth of specific services for older people, and practitioners should consider whether their existing services are capable of meeting the needs of older survivors.

The identification of the challenges that can affect some older people, particularly those that are different from younger groups, should be built into the support offered to older survivors. For example, some of the challenges observed by practitioners and described by survivors were based around accessibility of Rape Crisis centres where the survivor has complex needs, or finds it difficult to get into town centres. This may particularly be the case if the survivor lives in a care home or retirement setting, or in a rural area. Therefore, offering outreach and providing services in the survivor's home or a local community setting like a GP surgery can help address these challenges. Moreover, the age of the practitioner was considered important by practitioners in supporting older survivors and encouraging them to disclose their experiences; organisations should seek to recruit volunteers and staff across older age groups and increase the visibility of older people working in their organisations. One of the survivors in Phase 3 worked as a volunteer in her local centre and helped increase awareness of sexual violence in older age groups through delivering lectures and workshops to practitioners in the community and nursing students at the local community. Practitioners could consider whether this may be an appropriate model to adopt in their own services.

One of the issues described by practitioners was where the survivor was in a care home, which could create barriers to them disclosing abuse, particularly if the abuser was a carer. Practitioners stated

they did not have existing relationships with care homes and these could be developed to ensure information about their services are available in the home. Moreover, practitioners could deliver presentations at care homes to raise awareness of sexual violence and the support available.

7.4 The factors that influence older survivors' decisions to report sexual violence to the police or support organisation (Research Objective 4)

7.4.1 Summary of the findings

- It was estimated that between 30 per cent and 50 per cent of the older survivors, that practitioners had worked with, had reported to the police and all three of the survivors interviewed in Phase 3 had reported.
- Practitioners felt overall older people would be less likely to report than younger victims and felt that age created barriers to reporting.
- The three survivors who were interviewed in the study reported for different reasons, one wanted justice, one wanted to protect other women, and the third reported out of fear.
- Practitioners and survivors reported mixed experiences with the criminal justice system when they had reported.
- Practitioners felt the police should be involved in raising awareness of sexual violence in later life and encouraging older people to come forward.
- ISVAs can play an important role in supporting older survivors

The majority of sexual violence practitioners felt older people would be less likely than younger victims to report sexual violence to the police. A couple of practitioners said they felt older people would be more likely, based on their own experiences with older women, however they were

cautious about making this generalization as they had only limited experience with this age group. In general, a number of reasons why older people would be less likely to report were cited. The stigma and shame of having been raped in old age, a lack of trust in the police, and a lack of awareness of their rights were the main reasons practitioners felt older people would be less likely to report. Between 30 and 50 per cent of the women that practitioners had seen had reported to the police; none of the male victims practitioners had seen had reported. The main reasons why women had reported was because they were scared, they wanted justice and/or they wanted to protect other women from being raped. However, there were a number of reasons why women didn't report, linked to shame, not wanting their family to know, or fear of the police and criminal justice system.

In the survivor interviews, all three women had reported to the police and they cited different reasons for doing so. With Jennifer, she wanted justice but also to protect other women from being raped, as the perpetrator had threatened to do. For Winnie, she reported the rape because she felt what had happened to her was wrong, although at the time of the interview that case had not developed further as her main priority was getting her divorce. For the third survivor, Mary, she reported to the police because she felt scared and thought it was the right thing to do. The women described different experiences of the criminal justice system. For Jennifer, the experience had been very positive and she felt the police had really supported her. In her case, one of the two perpetrators had been prosecuted and found guilty in court, although the other perpetrator was found not guilty. For Winnie, she also described the police as being supportive and taking her seriously, however her solicitor had advised her against following through with the rape case and instead suggested she focus on the divorce. Mary had very negative experiences with the police, who had made her feel humiliated. The response had been inconsistent and at one point one of the officers had attended her home and asked her to undress so they could see her injuries, which left her feeling very

embarrassed and confused. The perpetrator was subsequently arrested but Mary found the process very stressful and had decided not to move forward with the case as she did not want to go to trial. However, Mary did not recall being offered an ISVA to support her through the process. Mary had mild learning difficulties and an ISVA may have been particularly helpful in explaining the process and supporting her through it. By contrast, Jennifer had an ISVA who she spoke very positively about and credited with helping her get through the trial. In particular, Jennifer had been given a tour of the court room prior to the trial so she knew what to expect and she described this as putting her at ease.

7.4.2 Priorities for future research

There is a need for research which examines the experiences of older sexual violence victims throughout the criminal justice system. Previous research in the domestic violence field has mainly focused on why people do not report, or the barriers to reporting (Seff and Stempel, 2008). However, very little is known about the approaches taken by police and other practitioners working in the criminal justice system, including Crown Prosecution Service decision making, and the experiences of older survivors who have gone through the CJS system following a sexual offence.

Furthermore, research which examines the reporting decision making by older survivors is needed to inform criminal justice policy and practice. Some research has suggested older women are less likely to report domestic violence than younger people (Blood, 2004; Pillemer and Finkelhor, 1988; Rennison and Rand, 2003) however very little is known about reporting for sexual violence.

7.4.3 Implications for policy and practice

Practitioners felt that the police could do a number of things to encourage older women to report rape. The biggest thing was raising awareness. Practitioners said that the police campaigns tend to focus narrowly on specific groups, usually young people and alcohol, and the night-time economy. Practitioners felt this could re-enforce the rape myths and stereotypes and further marginalise older women. It was suggested by several practitioners that police campaigns should be more diverse and think about a range of groups and that specific campaigns around older people should be considered.

Moreover, it has been found that police responses to domestic violence in later life may be centred on social care, viewing age as the primary issue (Southend Safeguarding Adults Board, 2011). There is a need for improved understandings of violence against older women, which shares many of the same dynamics as violence involving younger women, and appropriate responses should be based on domestic violence and sexual violence policy and practice, rather than social care.

The specific age-related issues that older survivors may face in the criminal justice system, for example limited mobility, sight or hearing problems and poor physical and/or mental health may make police questioning and the criminal trial process difficult and the criminal justice system should be sensitive to the specific needs of older survivors. Furthermore, Bench Book guidance to judges now encourages them to highlight and address some of the dominant rape myths and direct the jury not to base their discussions or verdict on these (Judicial College, 2016). This direction could incorporate the rape myths that may be particularly relevant to older survivors (for example that rape only happens to younger people).

ISVA support may be particularly beneficial for older victims who may have increased anxiety around the criminal justice system linked to generational understandings and relations with the police, who

traditionally did not intervene in 'domestic' situations and where police involvement was seen as a negative and something to be feared.

7.5 To examine the support needs of older survivors and the extent to which practitioners feel competent in meeting these needs and gaps in service provision (Research Objectives 5 and 6)

7.5.1 Summary of the findings

- Practitioners felt older survivors share similar support needs with younger survivors, namely emotional support, counselling, help with the legal process and practical support around housing and finances.
- Age creates a number of specific support needs; older people are more likely to need outreach support, particularly if they have mobility problems or are living in a care home.
- Dementia creates specific support needs, particularly for counselling and forensic medical examinations, however there is a lack of training and guidance in place and practitioners did not feel confident with managing these issues.
- Some practitioners found it emotionally challenging to support older survivors who associated age with reduced risked and found it particularly upsetting to think of older people being raped.
- The age of the practitioner is important in supporting older survivors; allocating support workers or counsellors or a similar age may be more comfortable for older survivors.
- There are a number of gaps in services, namely lack of relationships between sexual violence and age organisations; lack of awareness raising and campaigns around sexual violence in later life.

In general, practitioners felt many of the support needs older people have are the same as younger people, including emotional support, counselling, help with the legal process, help getting healthcare. However, age did create a number of specific support needs. In particular, practitioners felt older people were more likely to need outreach support as they may struggle to travel or access Rape Crisis centres or SARCs or may feel more comfortable in their own home or a local community setting like a GP surgery. Furthermore, some may be living in care homes where it would be impractical or even impossible to access centres.

One significant barrier, which is specific to older age groups and was a primary concern for practitioners was dementia. Some practitioners had provided support to old survivors with memory function issues and some with diagnosed dementia, and this created barriers for the survivor and challenges for the practitioner. Practitioners were concerned that older people with dementia may not be believed when they disclosed abuse and may be dismissed by carers, family or professional bodies. Furthermore, there are a number of specific ethical considerations for practitioners supporting those with dementia. For clinical practitioners providing physical examinations there are issues around consent and the best interests of the survivor. The lack of guidance around obtaining consent to perform examinations when the survivor has dementia was raised by a number of practitioners. Those who had provided counselling support stressed the need to weigh up the potential benefits and disadvantages of providing emotional support to people who struggle to remember the details of the sexual violence.

A number of societal level challenges were described by practitioners as acting as broad, macro-level barriers which may make it difficult for older people to access support for sexual violence. These centred on ageist attitudes and rape myths. The combination of ageist attitudes, which view older

people as asexual, (Calasanti and Slevin, 2001; Gott and Hinchliff, 2003) combined with 'real rape' myths and stereotypes, which link rape to male strangers attacking young, attractive women at night, have led to a lack of awareness or acceptance that rape can happen in later life. This may mean older people feel unable to access support services and may exacerbate feelings of shame, embarrassment and self-blame. Thus, 'real rape' stereotypes were a theme throughout all three phases of this research.

A number of gaps in support were identified. The biggest gap identified by practitioners and survivors was the overall lack of awareness among older groups that sexual violence services can offer support to victims of all ages and the types of services they offer. Practitioners felt the responsibility for this lack of awareness was multi-faceted. An overall societal ignorance and reluctance to accept that sexual violence can be perpetrated by, and against, older people means that many older people may feel sexual violence is a young person's problem. However, practitioners also felt they were at least partly responsible for the lack of awareness and felt their campaigns and marketing material could incorporate a wider range of people, including older people. Survivors also identified this as a gap; none of the survivors had seen any campaigns aimed at, or including, older women and felt there should be more awareness about sexual violence in later life. All three said this would have been helpful and may have encouraged them to seek support. Moreover, the location of marketing material was seen as important by practitioners and survivors, as the current posters and information cards/leaflets were often placed in locations where primarily young women would see them (for example in nightclubs, bars and university buildings) and practitioners and survivors felt these should be more widely available at other locations, for example breast screening clinics, churches and GP surgeries.

One area where practitioners in sexual violence and age-related organisations felt there was an obvious gap they could help address was the lack of multi-agency partnerships between national and local age-related organisations, such as Age UK, and Rape Crisis centres, SARCs, and domestic violence organisations. Age related organisations are well placed to disseminate information to older people and have relevant networks with other organisations, which could increase awareness. Moreover, by developing relationships this could open referral pathways between organisations enabling both sexual violence and age-related organisations to support older survivors of sexual violence. Some practitioners mentioned the gap in relation to services for specific groups of older survivors, in particular male survivors and survivors from black or minority ethnic groups, who may be more isolated or marginalised and felt specific campaigns and awareness raising should be aimed at these populations.

7.5.2 Priorities for future research

To date, little research has examined the specific needs of older sexual violence survivors. This study found a number of age-specific needs, including outreach services, specific support for survivors with dementia, and tailored support for those living in care homes. However, given the small number of older survivors that practitioners had worked with and the small number of survivors interviewed in Phase 3, there is a need for further research to examine these needs in more detail. Furthermore, in order to generate achievable policy strategies and development targets, the support needs of other older groups who have not accessed specialist sexual violence services should be explored.

Whilst research has examined the emotional impacts on counsellors and support workers (Etherington, 2000; Pack, 2004; Dunkley and Whelan, 2006) none have specifically examined this in

relation to older survivor service users. It was an interesting finding that several survivors in this study mentioned some of the personal challenges they had to overcome to support older survivors, and this requires further research to examine how these issues affect practitioners.

Very little has been written about dementia and the impacts of sexual violence (McCartney and Severson, 1997). Furthermore, very little is known about the support needs of people with dementia who experience sexual violence. There is a need for research which explores these issues in order to inform policy and practice guidance for sexual violence practitioners, care organisations and social workers.

7.5.3 Implications for policy and practice

Although many sexual violence support services already offer outreach services where required, older people may not be aware that this can be offered and this may act as a barrier to them accessing support. Targeted marketing material aimed at older people, which raises awareness of the range of services available, could address some of these gaps. This would be useful for both age-related organisations and sexual violence organisations, in order to bridge the current gaps across these services.

None of the age-related practitioners had received any specific training in their roles in relation to sexual violence. Furthermore, whilst many of the sexual violence practitioners said they covered a range of case studies and contexts in their training, few had examples of sexual violence against older people. This could be incorporated into training for new and existing staff to raise awareness of sexual violence in later life among practitioners and to increase understanding of some of the age-

specific issues older survivors may experience. This training could be done in conjunction with some older survivors themselves who can advise on the barriers they face or issues they experience.

One of the key areas where sexual violence practitioners lacked confidence was around the needs of older survivors who have dementia. None of the practitioners had specific training in this and none were aware of specific policies in their organisation on how to manage dementia and the implications this has for support services, in particular forensic medical examinations which require consent, and counselling which can cause secondary traumatisation if the survivor cannot consistently remember the rape or sexual assault. There is a need to develop training and policies on this to ensure practitioners are confident in managing issues related to dementia in the support service they provide.

A lack of existing relationships with age-related organisations, such as Age UK and Action on Elder Abuse (AEA) was highlighted by all sexual violence practitioners. Likewise, age-related practitioners interviewed in the study had no existing relationships with sexual violence organisations. This was an area practitioners felt they could develop by attending events held by organisations, joining committees or forums and approaching local centres about distributing material on sexual violence services to older people accessing the age-related organisations. This may increase awareness of sexual violence services but also develops referral pathways between age organisations and sexual violence organisations, which do not currently exist. Moreover, practitioners could work with age-related organisations in developing policies around issues such as dementia, and in delivering training to other local organisations such as primary health care or social services.

All of the practitioners from sexual violence and age-related identified a gap in current awareness campaigns which currently focus on young people, often linked to the night time economy and/or alcohol. This was identified as a barrier to older people accessing services or reporting sexual violence. On a local and national level, sexual violence campaigns could incorporate older people into the material to ensure they are inclusive of all age groups.

7.6 Contributions to knowledge

This research contributes to criminology, gerontology and feminist research and has implications across three fields: elder abuse domestic violence and sexual violence. Phase 1 of the research represents a new contribution to knowledge as the first study to examine the national extent of recorded sexual violence against older people, picking up where the CSEW cuts off. Whilst other studies have attempted to estimate the extent, this has been done using small samples from a single force which has then been extrapolated (Ball and Fowler, 2008). Given this data is not published because of the CSEW cap, this is the first time this data has been available. Furthermore, the method used to get this data, Freedom of Information requests, are an under-utilised method across social research. The reflections on the use of this method provided in Chapter 3 contribute to the limited available literature on using FOIs in criminological research. As described in Chapter 3.3.1, FOI requests are used widely by journalists and citizens, yet criminologists have been slow to utilise the act for criminal justice data or information relating to their own research. This thesis has highlighted the usefulness of FOI as a research method in criminological research. Moreover, this is the first time the use of FOI requests has been documented in feminist research and therefore offers a unique contribution to the feminist methodology literature.

Although the overall number of recorded offences involving a victim aged 60 or over was low, some of the data relating to the nature of the offences and characteristics of victims and perpetrators differ from what is observed in cases involving younger victims and challenges the 'real rape' stereotype that depicts rape as exclusively involving a young attractive female victim and a male perpetrator motivated by sexual desire. Moreover, it builds on the existing domestic violence and elder abuse research, which has traditionally focused on carers or partners as perpetrators of abuse; this research found acquaintances were the most common perpetrators followed by partners/husbands and strangers. This research has highlighted that cases reported to the police are most likely to involve a perpetrator which would put them outside of the definitions of elder abuse or domestic violence and thus highlights the need for sexual violence research to examine offences against older people to ensure violence perpetrated in all contexts is included in research. This contributes to our understandings of rape and provides a platform for future research to examine the differences, as well as similarities, in further detail.

Through qualitative interviews with practitioners and survivors this research examined the impacts, challenges and support needs of older survivors. To date, very few studies have explored these issues and none have done so through interviews with both practitioners and survivors. Only one previous study has included interviews with older survivors (Scriver *et al*., 2013) which included an interview with one woman who had experienced sexual violence in later life, however the focus of that research was on accessing services, therefore this is the first research to examine impacts, challenges, support needs and how age affects the experiences of survivors. Some of the findings from interviews with practitioners and survivors overlapped with findings reported in domestic violence against older people research, which have found generational norms and values, deeply imbedded shame and embarrassment can act as barriers (McGarry *et al*., 2011; Scott *et al*., 2004). However, this research

found a number of challenges not reported elsewhere, in particular dementia was mentioned by the majority of practitioners as a concern and they described the challenges this creates not only for survivors, who may find it difficult to report sexual violence or access support, but also for practitioners, particularly forensic medical examiners who have issues around gaining consent to perform examinations, and for counsellors who described difficulties where the survivor could not remember the rape during some counselling sessions.

This research makes an important contribution to the feminist and gerontological theoretical literature by drawing on a feminist-gerontological framework to examine sexual violence against older women. By combining these approaches, both age and gender became central to understanding how older women experience sexual violence. In particular, Kelly's (1988) concept of the continuum of sexual violence across the life course, the role of 'real rape' stereotypes that depict rape to involve young attractive women and the corresponding ageism across society that desexualises women as they age. Also feminist theories of invalidation and how malestream definitions and constructions have conditioned women to minimise and normalise their own experiences of violence, which may be further internalised by older women who were socialised into traditional gender roles and preceding the second wave feminist movement and subsequent developments in women's rights, were key to understanding the victimisation of older women in this research. All three themes cut across the three phases of empirical research. This is the first study to explicitly use a feminist-gerontological approach to examining sexual violence in later life and provides a useful basis for future research to build on this relatively new theoretical lens.

At a practitioner level, the research has already been used to develop a number of workshops which have been delivered to rape support organisations. On 25th November 2015 a workshop was

delivered to approximately 30 practitioners at the Rape Crisis England and Wales annual conference in Birmingham. On 30th November 2015 the findings from the research were presented at the 9th North East Sexual Violence Conference (Durham University) in Stockton to a mixed academic and practitioner audience, which included practitioners in local council, local health and rape support organisations. On 20th January 2016 a workshop was delivered to approximately 15 Rape Crisis Tyneside and Northumberland practitioners. A further training workshop has been arranged with Rape Crisis Tyneside and Northumberland and Age UK Ashington in January 2017 to raise awareness among practitioners in different fields working in the local area. Two information sheets, one for practitioners and one for survivors, have also been developed in collaboration with Age UK Teesside, Age UK Gateshead and Rape Crisis Tyneside and Northumberland. These will be distributed to all rape crisis and Age UK centres across the UK in either hard copy and/or digitally with the aim of increasing awareness of sexual violence in later life, developing relationships between rape crisis and Age UK organisations and providing older survivors with information on where they can access support services. A small grant from the Durham University Wolfson Research Institute funded the design and printing of the guides.

7.7 Reflections on the research journey

This study adopted a mixed-method approach, utilising an infrequently used method in social research, Freedom of Information requests, to examine the extent and nature of police recorded sexual violence against older people, and qualitative interviews with sexual violence practitioners and female survivors of sexual violence in later life, to examine the impacts, support needs and gaps in services for older survivors. This is the first feminist study to adopt this methodological approach to examining sexual violence in later life and has highlighted the benefits and strengths of using FOI as both a standalone method and alongside other, qualitative methods to examine violence against

women. FOI requests were particularly helpful in this study as there was no existing public data on the extent of recorded offences involving older victims, allowing this research to gain access to previously hidden data. Furthermore, as older victims may be a particularly hard-to-reach population, for example because they live in care homes or have conditions such as dementia, which would make other methods, such as surveys and interviews, more difficult, FOI requests are a way of gaining data on this population.

Using FOI requests meant a large enough sample of cases (n=656) could be analysed, which allowed for patterns in relation to victim, offender and assault/incident characteristics to be identified and discussed and compared with the existing available data on younger victims. Interviews with practitioners filled some of the gaps in knowledge that the FOI data could not elucidate, for example the challenges in accessing services and the support needs of older survivors. Furthermore, interviews with older women who had experienced sexual violence provide rich data on the physical and mental health consequences and impacts of rape and how age affects these experiences and needs. Using a mixed-method approach was therefore successful in contextualising the extent of older women reporting incidents of sexual violence but also the challenges, impacts and support needs following sexual violence. Taking a sequential approach to mixed methods (Driscoll *et al*., 2007) enabled depth in these qualitative phases and breadth in the quantitative phase. Together, these provided the 'bigger picture' and the 'personal story' which is one of the primary advantages of using mixed-methods.

The data on cases collected through the FOI requests were useful in informing interviews with practitioners, as this data was used to prompt discussion and draw comparisons with the number of older survivors these organisations had seen. However, using FOI requests is not without limitations;

in this study, two forces refused to provide the data through FOI requests and instead had to be approached using existing contacts in those forces. Furthermore, there was a lot of missing data across the different variables in the individual datasets provided by forces, which meant the total amount of data available to analyse in each variable differed significantly. In particular, data on the ethnicity of victims and offenders was very patchy; most forces had very little available data on this. This highlights a key limitation of FOI requests, in that they can only collect data which is actually collected and available by the public body, and varying practices on data collection can severely limit the availability of information.

A key limitation of the case studies with older survivors is the small sample of just three women. Initially, it was anticipated that a sample of between five and 10 interviews would be achievable, based on previous domestic violence research with older women. However, despite adopting a variety of approaches for recruiting older people who had experienced sexual violence, I was not able to recruit a larger sample. The primary reason for this was the low number of older women (and men) accessing sexual violence services; most of the practitioners who were interviewed in Phase Two of the research were not currently working with or supporting any older survivors who had experienced sexual violence since the age of 60, therefore promotion of the research to older people accessing services was limited. Other attempts to recruit older people through online forums, namely Gransnet, were not successful. However, only one previous study (Scriver *et al*., 2013) has included qualitative interviews with older survivors and that study only recruited two older women, of which only one had experienced sexual violence in later life.

My interest and motivation in conducting this doctoral research examining sexual violence against older women was linked to my feminism and my passion for making visible the extent of men's

violence against women, regardless of age. I found it frustrating that older women had been excluded from the majority of research and activism around sexual violence and wanted to conduct research which would make a positive contribution to social change for older survivors of sexual violence. When I began this research journey I had some experience of researching other forms of violence against older people, specifically domestic violence against older women, and felt this experience had prepared me for this doctoral research. However, I had not anticipated the difficulties I would encounter, not only in recruiting older survivors to be interviewed but also the emotional challenges in listening to the accounts of these women. The experiences of sexual violence described by the three women were difficult to hear, in part because they are so infrequently heard and the real rape myths have conditioned society to view sexual violence as a younger persons' issue. Furthermore, as a young woman asking women more than 30 years older than me about their experiences, I was very much an 'outsider'. Although I did not feel this impacted negatively on the interviews themselves, I was acutely aware of the age differences and this concerned me throughout the process. Therefore, researchers should be aware that age differences when interviewing older people is not necessarily a barrier; being an outsider in this respect can actually be beneficial and may help older people to open up about their experiences as they do not have to negotiate generational attitudes that may impinge these discussions with their peers.

7.8 Conclusion

Despite decades of feminist research on sexual violence, little is known about the extent, nature and impacts of sexual violence against people aged 60 and over. The well-established age-crime curve

suggests victimisation of all crime, but in particular violent crime, reduces with age and it has generally been assumed that the risk of experiencing sexual and domestic violence decreases in later life. However, a small number of studies have emerged which challenge these assumptions, with domestic and sexual violence research revealing these offences occur across the lifespan. This thesis is the first UK study to examine the extent, nature and impacts of sexual violence against people aged 60 and over and builds on the small international pool of existing literature.

This research has contributed to a much greater depth of understanding of the extent of recorded sexual offences against people aged 60 and over in the UK, the importance of gender and age in these cases, and the similarities and differences in these offence characteristics compared with rapes of younger people. The findings also furthered understandings of the physical and psychological impacts of rape, the challenges in accessing support services and the support needs of older women. This research makes a number of original contributions to criminological, gerontological and feminist literature, specifically sexual violence, domestic violence and feminist research more generally, and has identified where future research must focus in order to build on these findings.

Conducting this research, in particular listening to the stories of the three women survivors, has been a privilege for me. I feel incredibly honoured that these women placed their trust in me to tell their stories with the shared goal of raising awareness of sexual violence in later life and improving responses for older survivors. In a wider sense, examining the scope of sexual violence through FOIs has been important as a method of uncovering previously hidden truths and I hope this starts a new conversation about this previously invisible topic. It is my sincere hope that this thesis is the starting point for further research and a more open discussion of sexual violence against older women which

leads to improved efforts to prevent sexual violence against women across the life course and respond to the needs of all survivors.

Appendices

Appendix 1: Inclusion and exclusion criteria

Inclusion Criteria	Explanatory notes
1. Recorded incidents involving a victim aged 60 or over at the time of the incident	The focus of the present study was on sexual victimisation of older people, rather than reports from older people who experienced abuse as a child or adult (typically referred to as historical sexual abuse). Whilst the increase of people coming forward in later life reporting historic abuse has been documented, there is a lack of research or policy attention on the incidence of sexual violence in later years.
2. The gender of victim and suspect/perpetrator	Data were requested on the gender of both victims and perpetrators in cases where the victim was aged 60 or over at the time of the offence. This allowed comparison with the general sexual violence literature which reports victims are overwhelmingly female, and perpetrators are male.

3. The age of victim and suspect/perpetrator	The age of both the victim and suspect/perpetrator at the time of the incident was important to allow comparison with existing research findings and current knowledge about sexual violence against younger populations.
4. The ethnicity of the victim and suspect/perpetrator	The ethnicity of the victim and perpetrator in cases involving a victim aged 60 or over were requested in order to examine any patterns in relation to sexual victimisation of older people compared to younger age groups. The majority of the existing literature has not collected data on ethnicity of victims or perpetrators and this is an important gap which needs addressing.
5. The location of the incident	The majority of existing studies in this area have reported the majority of sexual violence incidents occurred in the victim's home, similar to younger populations (Home Office, 2015). However, some studies have suggested a high occurrence in care or residential home. It was therefore important to examine the location of recorded sexual offences.

6. The relationship between the victim and suspect/perpetrator	The existing research reports contradicting findings, with early studies suggesting the perpetrator was most likely to be a stranger with more recent research suggesting the perpetrator was an acquaintance and elder abuse studies finding. It is therefore important that data on the relationship is examined to draw comparisons with younger populations and the existing research.
7. Whether the perpetrator is a known serial offender	Some of the existing research has reported that convicted offenders who have victimised older people have previous convictions for sexual offences. In order to build on this knowledge, forces were asked if suspects/perpetrators in the identified cases were known or suspected to be serial offenders.
8. Whether the offence was linked to any other crime	The media often depicts sexual violence against older people to be an opportunistic act in the context of another, primary crime (often a burglary or mugging). This has been supported by some of the research in this area which has reported a link between rapes and

	sexual assaults against older people and other crimes. It was important to explore whether the cases identified by forces in this study were linked to any other crime. However, as this was not itself the primary focus of the study, details on the type of offence linked to the sexual violence was not requested.

Appendix 2: Freedom of Information Questionnaires

Aggregate Data Questionnaire

1. In total (for all ages), how many crimed incidents of rape (s1 Sexual Offences Act) and sexual assault by penetration (s2 Sexual Offences Act) were recorded in your force between 1st January 2009 and 31st December 2013?

	s1 Rape	S2 Sexual assault by penetration
1st January 2009 – 31st December 2009		
1st January 2010 – 31st December 2010		
1st January 2011 – 31st December 2011		
1st January 2012 – 31st December 2012		
1st January 2013 – 31st December 2013		
Total		

2. How many of these (number not percentage please) involved a victim who was **aged 60 or over at the time the assault took place?**

	s1 Rape	S2 Sexual assault by penetration
1st January 2009 – 31st December 2009		
1st January 2010 – 31st December 2010		
1st January 2011 – 31st December 2011		
1st January 2012 – 31st December 2012		
1st January 2013 – 31st December 2013		
Total		

3. For each of the incidents that you refer to in question 2 above (where the victim was aged 60 or over at the time of the offence) please fill out the attached form. Please anonymise this data and use either a number or a reference for each case. Please complete one form per incident except where there is more than one perpetrator – in these cases please use the same reference number and complete multiple forms.

Individual Data Questionnaire

Sexual Violence against people aged over 60 – individual incident details

Year of incident: ..... s1 Rape or s2 Sexual Assault by Penetration: .....

Anon ref number (e.g. numeric or your ref)	Gender of victim	Ethnicity of victim (self-defined)	Gender of perpetrator	Ethnicity of perpetrator (self-defined)	Age of victim at the time of the offence	Age of perpetrator at the time of the offence	Relationship of PERPETRATOR to the victim	Location of the rape or assault	Linked to any other crime	Known Serial Offender (sexual offences)
1.	Male Victim ☐ Female Victim ☐		Male Perpetrator ☐ Female Perpetrator ☐		60-69 ☐ 70-79 ☐ 80-89 ☐ 90-99 ☐ 100 or over ☐	16 or under ☐ 17-20 ☐ 20-29 ☐ 30-39 ☐ 40-49 ☐ 50-59 ☐ 60-69 ☐ 70-79 ☐ 80-89 ☐	Partner or husband ☐ Child ☐ Grandchild ☐ Other family member ☐ Un-related carer ☐ Friend ☐ Neighbour ☐ Acquaintance ☐	Victim home ☐ Perpetrator home ☐ Victim & Perpetrator's home ☐ Care home, hospital or nursing home ☐ Public outside location ☐ Public indoor	Yes ☐ No ☐ Unknown ☐	Yes ☐ No ☐ Unknown ☐

						90-99 ☐ 100 or over ☐	Stranger ☐ Unknown ☐ Other ☐	location ☐ Other ☐ Unknown ☐		

Any other relevant information:

Appendix 3: Interview schedule with women survivors

DRAFT INTERVIEW SCHEDULE

Guidance for interviewer

(This is what I will go through with the women)

Thank for you agreeing to participate in this research and talk to me today, I really appreciate it. Hopefully you have already seen the information sheet and know a bit about the study, but just to confirm, the study is exploring the experiences of women over the age of 60 who have experienced rape or serious sexual assault. My aim is to hear the voices of women over 60 who have experienced recent rather than historical sexual violence, who have not been included before in research and campaigns around sexual violence.

- **Consent – Before we begin the interview I have a consent form for you to sign. Are you happy to read this or would you like me to talk you through it?**

- *I just want to make sure you are comfortable talking to me today and to assure you that you can withdraw from this interview and study at any point. If you feel upset at any point and want to stop the interview or take a break, please just let me know. If you want to withdraw your contribution after the interview, that is also fine, please just let me know. The support service you are working with are available to talk to you if you feel you would like some extra support during or at any point after the interview.*

- **Do you have any questions before we begin?**

This interview is expected to last about 45 minutes but I've got plenty of time so don't feel rushed, talk as much or as little as you want. There are 17 questions:

About you

1. Can you tell me a little bit about yourself? (e.g. age, have you always lived locally, do you have any children/grandchildren)

2. How have you come to be involved in this research? (e.g. support worker)

Help seeking

3. Have you been seeing this person (support worker, counsellor etc.) since it started or last happened or did it take you a while to get in touch?

4. How did you find out about them/know where to go for support?

5. What other support services did you contact, if any? (and how was your experience with them?)

6. As this research is just about women aged 60 and over, do you mind if I ask, do you think your age made it any more or less difficult to find support?

7. Did you contact the police at all? What happened?

8. Do you think you were treated any differently because of your age? Do you think you experienced the process differently than if you were younger?

9. Did you have a medical examination at any point? If so, what happened? (and again do you think you experienced the process differently than if you were younger?)

10. Did you tell any age-related organisations about what had happened – e.g. Age UK (why/why not?)

11. Did you talk to any friends about it, either in person or on an online site likes gransnet?

Impacts

12. Thinking next about the impact that the rape/sexual assault/s had on you, how would you say it affected the way you live your life?

a. Has it changed the ways in which you relate to other people? E.g. friends/family

b. Has it changed the ways in which they treat you?

c. Has it changed the things you do, for example where and when you go out?

13. Thinking about the impacts on your life you have just described, do you think these would have been the same or different if it had happened earlier – or, if it did also happen earlier in life, how did it differ?

Change

14. Do you think society (the media, friends and family, government, police etc.) know enough about rape of older women? What should they know/do?

15. What support do you think should be available?

16. Do you think there is enough awareness that rape and sexual assault can happen to people who are aged over 60?

17. Is there anything else you want to tell me?

Thank you very much for contributing to this research and sharing your experiences, it is very much appreciated.

Appendix 4: Information Sheet

Durham University

Sexual Violence against Women Aged 60 & Over

Purpose of the study

The main aim of this PhD research is to gain a better understanding of the impacts of rape or sexual assault against women aged 60 and over. This is an under-researched area internationally

It is critically important that we listen to the voices of women who have experienced sexual violence. I am interested in hearing about the experiences of women and what support they were offered or would have liked to have been offered, in order to better inform specialist support organisations.

What participating in the study will involve

We are seeking women aged 60 or over who have experienced sexual violence to participate in a one hour interview. Interviews will focus on the impact your experiences have had on your life, whether you have received any support from agencies, what support you feel you wanted or needed and the extent to which you feel you received that support. Interviews will be conducted between April 2015 and September 2015.

Interviews will be confidential and all contributions made during the interview will be anonymised. Interviews will take place at a time and place convenient to you, or over the telephone.

To find out more information or to arrange an interview, please contact me using the contact details below.

Principal researcher: Hannah Bows - Hannah.Bows@durham.ac.uk
07964 003062

Supervisors: Professor Nicole Westmarland (Nicole.Westmarland@durham.ac.uk) and Ms Helen Charnley (H.M.Charnley@durham.ac.uk).

Appendix 5: Consent Form

Consent form for sexual violence against people over 60 study

The University of Durham

Researcher: Hannah Bows

Email: hannah.bows@durham.ac.uk

I am willing to participate in an interview for the above mentioned study and have had the scope and purposes of the study explained to me and understand how the information I disclose in the interview will be handled. Yes /No

I consent to the interview being tape recorded. Yes/No

I understand that in the event of any disclosures on my part that highlight risk of serious harm to myself, a third party or a child this information will need to be shared with other agencies to ensure the safety of myself or others. Yes/No

I understand that my contributions will be anonymised and personal names will not be given, however my professional position may be referred to in the study. Yes/No

I understand that my contributions are confidential and it will not be possible to trace back any information I provide to you. Yes/No

I understand that I have the right to request copies of the transcript and/or final research report. Yes/No

I understand that I can withdraw for the study at any time, including during the interview or at any point after the interview up to the date of September 2016 when the report is due for submission.

Yes/No

I understand that I have the right to refuse to answer any question or discuss any topic that I do not want to talk about. Yes/No.

I understand that in the event I am unhappy with the way I am treated in the course of my participation in this study or if I have any concerns about the conduct of the researchers then I can address these complaints or concerns to Professor Nicole Westmarland (my supervisor). Her contact email is: Nicole.Westmarland@durham.ac.uk. Yes/No

I agree to participate in this research project:

_____ _____

*Participant's Signature Date

Participant requires a copy of consent form? YES/NO

I have explained and defined in detail the research procedure in which the respondent has consented to participate. Furthermore, I will retain one copy of the informed consent form for my records.

___________________________________ ___________________________

Researcher's Signature Date

Appendix 6: Durham University Ethics Form

RESEARCH ETHICS AND RISK ASSESSMENT FORM

All research that involves access to human participants or to personal data with identifiable cases must be assessed for ethical issues and risks to the research participants and researcher(s)[6]. The research ethics form starts this process and must be submitted by the principal investigator for *all* such projects that staff or students of the School intend to undertake. Students and PGRs completing the process should seek guidance and support from supervisors. Staff members are invited to seek advice and support from the co-chairs of the SASS ethics sub-committee. Research that is purely literature-based does not require ethical approval.

Applications for ethical approval are reviewed in line with relevant codes of ethical practice, such as that of the British Sociological Association [7] or ESRC Research Ethics Framework[8]. Data should also be handled in a manner compliant with the Data Protection Act[9]. Researchers seeking funding from a research council must work within the appropriate research ethics framework.

When completed, this form should be submitted to the designated approver for your type of project. The form must be approved before any data collection begins.

Type of project	*Default Approver*
Students undertaking dissertations on taught courses (including MSW students)	Your dissertation supervisor
All other students undertaking project work as part of taught modules	Your module convenor or workshop leader
Research students	Director of Postgraduate Research (via SASS Research Secretary (PGR))
Staff	Chair of Ethics Sub-Committee (via SASS Research Administrator)

[6] http://www.dur.ac.uk/research.office/local/research_governance/
[7] http://www.britsoc.co.uk/equality/Statement+Ethical+Practice.htm
[8] http://www.esrc.ac.uk/about-esrc/information/research-ethics.aspx
[9] http://www.dur.ac.uk/research.office/local/research_governance/data_protection/

PART A. To be filled in by all applicants
Section A. I Project outline

Name of investigator: Hannah Bows

E-mail address: Hannah.bows@durham.ac.uk

Dissertation/project title: Rape and serious sexual assault against 'older women'

Degree and year (students only): PhD (year 1)

Student ID (students only):

Project funder (where appropriate): N/A

Estimated start date: 01/06/2014 **of project**

Estimated end date: 30/09/2016 **of project**

Summary (up to 250 words describing main research questions, methods and brief details of any participants)

Dissertation/project title

Rape and serious sexual assault against 'older women' aged 60 and over

Main research aims/questions

1. To analyse data from a number of police forces in England in order to examine the number of reported rapes or sexual assault by penetration (hereafter serious sexual assault) (s1 and s2 of Sexual Offences Act, 2003) against women over the aged of 60 in the last five years, with particular focus on the nature and characteristics (including time, location and victim-offender relationship and level of violence used).

2. To explore the impact of rape or serious sexual assault against women aged 60 and over with a view to understanding how the violence has affected their lives and what support needs they present.

3. To explore the extent to which the current specialist age related and rape/serious sexual assault support services feel able to support women aged over 60 who have been raped/sexually assaulted.

4. To examine the current sexual offences legislation and associated policies in order to evaluate the extent to which the needs of older women are considered/provided for.

Proposed methods

1. Quantitative analysis of police recorded data and statistics.

2. Qualitative semi-structured interviews with women aged 60 and over.

3. Semi-structured individual or group interviews with specialist staff and volunteers from age-related organisations and specialist rape/sexual assault support organisations.

4. Qualitative analysis of the Sexual Offences Act and associated policies (e.g. sentencing).

Sample/participants

1. Anonymised data of recorded rapes/serious sexual assaults against women aged 60 and over from the last five years from a sample of police forces.

Access to police data will begin with an initial invitation to each force rape lead in England and Wales (44 in total) to participate in the study. Forces will be asked for anonymous data according to the questionnaire (attached). The initial questionnaire asks for the total number (all recorded incidents) of section 1 or 2 offences under the Sexual Offences Act 2003, namely rape and sexual assault by penetration against a female aged over 13 in the last five years. The questionnaire then asks for the proportion of incidents involving a woman aged 60 and over and how many of these incidents occurred with women aged 60 or over at the time of the offence.

A follow-up questionnaire (attached) has been designed to collect data on specific variables of incidents involving female victims aged 60 or over at the time of the offence. Inclusion criteria for the study is that the rape or serious sexual assault occurred when the victim was aged at least 60 (excluding those who reported the offence after the age of 60 but where the time of occurrence was before the age of 60). Data requested is:

1. The age of the victim at the time of the rape or assault
2. The age of the perpetrator where known
3. The victim-perpetrator relationship
4. The location of the assault by category (residential-victim, residential-perpetrator, public place, care home or healthcare institution, other public, other private).
5. Level of violence used where known (i.e. weapon)

2. Although no pre-determined number has been set, a minimum of ten qualitative interviews with older women across England is the initial aim.

A convenience agency-based snowball sampling technique will be adopted. Exiting links with organisations through CRiVA will be contacted initially with further agencies contacted through snowball or convenience selection technique. Those agencies who agree to participate will then be asked to promote the research to women who meet the inclusion criteria, namely:

1. Have been raped or seriously sexually assaulted since the age of 60.
2. Are currently receiving support and engaging with the host support service.
3. Are able to understand the purpose of the study and what is expected and are able to give consent to participate.

4. The support service they are accessing are able to support the victim-survivor's participation including providing relevant support if the interviews raise issues that upset or distress the participant.

In addition, participants will be recruited through online message boards and forums for older people, including Gransnet – an online message board forum, similar to mumsnet. A recruitment letter is attached (Appendix A) which will be posted on the websites under appropriate message board of forum topics (e.g. health and wellbeing, research, sexuality'). The letter provides the opportunity for respondents to email the researcher or reply to the thread, however it is highlighted that using the latter method may identify the respondent, so email should be used if preferred to protect their identity. However, the majority of forum users will have 'usernames' which are pseudonyms which inherently provides a level of anonymity. Support services available to those who do, or do not, wish to be involved in the research will be highlighted and this offers an opportunity to promote the available services to those who are interested in receiving support.

3. A sample of twenty specialist staff and volunteers (10 from age related organisations and 10 from rape/sexual assault organisations)

Professionals working at specialist rape and sexual violence services will be recruited through an initial email sent to all identified organisations (see attached) inviting them to participate in interviews. Those who agree will also be asked to recommend other relevant professionals with the aim of snowballing the sample to recruit more participants.

Professionals working at a range of age-related organisations will be approached through an initial email inviting them to participate in the study. Initially, organisations in the North East will be approached using existing links with research groups and my supervisor, Helen Charnley. Again, it is hoped a snowball sample will develop from this.

An initial list of potential contacts has been drawn up and is attached. Again, those who express interest in the research will be asked to recommend other professionals or services to contact with the aim of snowballing the sample.

Section A.2 Ethics checklist (please answer each question by ticking as appropriate)

	Yes	No
a). Does the study involve participants who are *potentially* vulnerable for example, children and young people; those with a learning disability or cognitive impairment; those unable to give informed consent or individuals in a dependent or unequal relationship?	☒	☐
b). Will it be necessary for participants to take part in the study without their knowledge/consent (e.g. covert observation of people in *non-public* places)?	☐	☒
c). Could the study cause harm, discomfort, stress, anxiety or any other negative consequence beyond the risks encountered in normal life? Does the research address a sensitive topic?[10]	☒	☐
d). Will financial inducements (other than reasonable expenses and compensation for time) be offered to participants?	☐	☒
e). Will the project involve the participation of patients, users or staff through the NHS or a social services department?	☐	☒
f). Will you be required to undertake a Criminal Records Bureau check to undertake the research?	☒	☐
g). Are appropriate steps being taken to protect anonymity and confidentiality? (in accordance with an appropriate Statement of Ethical Practice).	☒	☐

If you have answered 'yes' to any of questions a) to f) or 'no' to question g), you must complete Part B of the form. Now go to Section A.3.

Section A.3 Risk assessment checklist

	Yes	No
a). Does the study involve practical work such as interviewing that requires the researcher(s) to travel to and from locations outside the University?	☒	☐
b). Does the study involve accessing non-public sites that require permission to enter?	☒	☐
c). Are there any identifiable hazards involved in carrying out the study, such as lone working in isolated settings?	☐	☒

If you have answered 'yes' to any of questions a) to c), you must complete Part C. of this form.

Section A.4 Next steps

a) If *only* Part A is required, please go to Part D of the form and ensure you complete the checklist and sign the completed form. Submit the form to the designated approver

[10] Sensitive topics can include participants' sexual behaviour, their illegal or political behaviour, their experience of violence, their abuse or exploitation, their mental health, or their gender or ethnic status. Elite Interviews may also fall into this category.

b) If you need to fill in Part B (this is required if you have answered ‘yes’ to any of questions a) to e) in Section A.2) please continue and complete Part B and add any further attachments.

c) If you need to fill in Part C (this is required if you have answered ‘yes’ to any of the questions in Section A.3) please continue and complete Part C.

PART B

Part B must be completed if you have answered 'Yes' to any of questions a to e in Section 2 of Part A.

Section B.1 Other approvals

If your project requires approval from an NHS or Social Services ethics committee, you should submit a draft NHS/SS application to your designated approver within SASS, along with this form, prior to submission to the appropriate external ethics committee. If you are submitting a draft NHS/SS to your designated approver within SASS, you only need to complete Section 1of Part B. Once approval has been granted by SASS, including meeting any conditions, you must submit the approved forms together with evidence of this approval. Researchers undertaking studies in an NHS or social services setting must abide by the *Research Governance Framework for Health and Social Care*[11].

a) Does the research require ethical approval from the NHS or a Social Services Authority?

Yes ☐ No ☒

If 'Yes', please ensure the draft documentation is attached.

b) Might the proposed research meet the definition of a clinical trial? It may do so if it involves studying the effects on participants of drugs, devices, diets, behavioural strategies such as exercise or counselling, or other 'clinical' procedures.

Yes ☐ No ☒

If 'Yes', a copy of this form must be sent to the University's Insurance Officer, Procurement Department. Tel: 0191 334 9266. Insurance approval will be necessary before the project can start and evidence of approval must be attached with this form.

Section B.2 Project details and ethical considerations

a) **Who are your research participants? (please describe sample size, characteristics and sampling procedure)**

The sample will be generated by combining purposive sampling, a form of non-probability sampling where the researcher seeks a sample that is relevant to the study with a suitable variety of key characteristics (Bryman, 2008); and snowball sampling, where contact is made with people relevant to the study area and who are then used to help identify further suitable participants (Bryman, 2008).

11 http://www.dh.gov.uk/en/Aboutus/Researchanddevelopment/AtoZ/Researchgovernance/DH_4002112

It is anticipated that the sample will consist of approximately:

Anonymised data from police forces across England and Wales.

Ten women aged 60 and over who have experienced sexual violence since turning 60.

Ten specialist staff/volunteers working in age-related organisations.

Ten specialist staff/volunteers working in rape/sexual assault organisations.

b) Are there any people who will be excluded? If so state the criteria to be used

Yes - due to the nature of purposive sampling discussed above, the sample will be made up of those people who are specifically relevant to the study – i.e. women who have experienced serious sexual violence (as per s1 and s2 SOA 2003) since the aged of 60 and who are currently engaging with and receiving support through a rape or sexual assault support service. Due to the nature and scope of the study, those with diagnosed dementia will not be included in the sampling due to issues around informed consent and a lack of training/appropriate skills of the researcher.

c) Who will explain the investigation to the participant(s)? And how? (attach information sheet or similar)

An information sheet will be provided to all participants in advance of the study to explain the purpose of the study, what the study will involve and their right to refuse to participate at any point. This will also be read to participants before beginning the interview. A copy of these information sheets is attached.

d) How and where will consent be recorded? (attach consent form)

A consent form has been specifically designed for victim-survivors and professional participants and are attached to this application. Consent will also be discussed verbally before each interview to ensure participants understand the consent procedure.

e) What steps will be taken to safeguard the anonymity of records, to maintain the levels of confidentiality and security of data storage promised to participants and to ensure compliance with the requirements of the Data Protection Act?

All professional participants in the study will be protected by being assigned a number or choosing a pseudonym to protect their identity. Interviews will be recorded, with prior permission from participants, but will be destroyed once the data has been transcribed and used in the report. Any potentially identifying information will be removed from transcripts and will not be included in any written research documents. Participating police forces will be asked to anonymise the data requested and remove any identifying information. Professionals working at age-related or sexual violence organisations will be referred to by the type of organisation they work for and their broad job title (for example 'counsellor at south east England sexual violence organisation'). All data provided by victim-survivor participants will be pseudonymised (a 'false name' chosen by the participant or assigned by the research if the participants prefers) and, if small samples are used, will ensure participants and data cannot be traced back to the individuals who provided it.

f) Will non-anonymised questionnaires, tapes or video recordings be destroyed at the end of the project?

Yes ☒ Go to B.3 No ☐ Go to next question Not Applicable ☐ Go to B.3

g) What further use do you intend to make of the material and how and where will this be stored?

h) **Will consent be requested for this future use?** Yes ☐ No ☐Not Applicable ☐

Section B.3 Risk or discomfort to participants[12]

What discomfort, danger or interference with normal activities could be experienced by **participants**? State probability, seriousness, and precautions to minimise each risk.

Risk/Discomfort	Probability (high/medium/low)	Seriousness (high/medium/low)	Precautions
Trauma experienced by participants from discussing	High	High	If participants become distressed or upset they will be offered break and/or re-offered

[12]For further guidance applicants can consult *Social Research Update*: *Safety in Social Research* http://sru.soc.surrey.ac.uk/SRU29.html and the *Code of Safety* developed by the Social Research Association http://www.the-sra.org.uk/guidelines.htm#safe

experiences of sexual violence	Low	Medium	the option to stop the interview. Support workers will be available to refer to.
Trauma experienced by researcher as a result of hearing participant stories.	Low	High	University counselling service available, mentoring and support from supervisors.
Further violence from perpetrators or family members			As well as contributions being anonymised, interviews will take place in a safe environment away from perpetrator at the support service where victim-survivors are accessing support. A full risk assessment and safety protocol which applies to the Mirabal project (a project currently ongoing in the School of Applied Social Sciences, overseen by

			Professor Nicole Westmarland) will be followed.

PART C. FIELDWORK RISK ASSESSMENT AND HEALTH DECLARATION

All applicants who intend to conduct research with human participants outside the University should complete these forms. For further guidance please consult the University's Health and Safety Manual Section F1 at: http://www.dur.ac.uk/resources/healthandsafety/manual/f1.pdf

Section C.1 Fieldwork Risk Assessment (participants and researcher)

DEPARTMENT SASS	LOCATION Various – premises of sexual violence support organisations.
ACTIVITY Interviews in the community	PERSONS AT RISK Hannah (researcher)
DURATION OF ACTIVITY Approximately 90 minutes each	
POTENTIAL HAZARDS: Risks associated with everyday life e.g. travel accidents	
POTENTIAL CONSEQUENCES: Harm caused	
EXISTING CONTROLS: Relevant insurance, following risk assessments and existing protocols for Mirabal project (an ongoing longitudinal project within the School of Applied Social Sciences, overseen by Professor Westmarland, examining domestic violence perpetrator programmes).	
RISK RATING (SEVERITY X LIKELIHOOD) WITH EXISTING CONTROLS	
HIGH □ Severity HIGH Likelihood LOW = Risk Rating .....MEDIUM □ LOW ✓	
NEW CONTROLS REQUIRED: .	
RISK RATING (SEVERITY X LIKELIHOOD) WITH NEWCONTROLS	
HIGH □ Severity ..... X Likelihood ..... = Risk Rating .....MEDIUM □ LOW □	
ASSESSOR NAME ..... JOB TITLE ..... SIGNATURE ..... DATE	

Section C.2 Fieldwork Health Declaration

During your research you may undertake one or more periods of fieldwork, involving visits to locations some of which will require a reasonable degree of physical health and fitness. In order to ensure that each research project operates with due regard for health and safety - in addition to being rewarding for those involved - all students and staff who expect to participate in fieldwork must declare any medical condition or incapacity which could prevent them from fully participating in the expected activities, or which may endanger the health and safety of themselves and others. As a condition of undertaking the research, you must complete the form below, after first becoming familiar with the details and expectations of the proposed fieldwork activities. All information will be treated in the strictest confidence and used only for determining the suitability of a fieldwork activity.

Please note that answering YES to any of Part B does not automatically exclude you from a fieldwork activity and every effort will be made to provide alternative arrangements where these are necessary, but it is essential that you provide full information. Where YES is answered, or the Part C declaration is not signed, the matter will be referred for a further medical opinion.

PART A

Department of Applied Social Sciences

Location of research: Durham & Darlington Start and End dates 1 May 2014 - 30 September 2016

Name of researcher: Hannah Bows Name of supervisor: Dr Nicole Westmarland

PART B

Do you have a medical condition, allergy or intolerance that may restrict your taking part in the expected fieldwork activities?

NO

DETAILS _____

Do you have any physical injury or incapacity that may restrict your taking part in the expected fieldwork activities?

NO

DETAILS _____

Do you take medication to control any of the above conditions?

NO

DETAILS _____

PART C

I declare that I am not knowingly suffering from any medical condition or disability that could prevent me from participating fully in the fieldwork activities.
My last tetanus booster was on – not known.

Signed: Hannah Bows Date: 14th May 2014

PART D. CHECKLIST AND SIGNATURES

Section D.1 Checklist of attachments

All applicants should tick which parts of the form you have completed and the documents you are attaching with this form:

1. Part A (all applicants)	☒
2. Part B (for research with vulnerable people, on sensitive topics, etc)	☒
3. Part C (for research outside the university)	☒
4. Completed draft NHS or social services ethics form (students only, if applicable)	☐
5. Confirmation of insurance cover (if applicable; see Part B, section B.1.b.)	☐
6. Information sheet for participants (required if consent is to be obtained)	☒
7. Consent form for participants (required if consent is to be obtained)	☒
8. Draft questionnaire (required if you are using a questionnaire)	☐
9. Draft interview/focus group guide (required if you are using interviews/focus groups)	☒
10. Written confirmation from all agencies involved in the study that: a. they agree to participate; b. a CRB check is or is not required. (STUDENTS ONLY ARE REQUIRED TO SUBMIT THIS - the agreement to participate may be 'in principle', pending ethics approval by the university or the agency. An e-mail from a manager or other appropriate gatekeeper is acceptable).	☒

Section D.2 Signatures

All applicants must complete this section

Principal Investigator[13]

Name: Hannah Bows Date: 14th May 2014

Supervisor/tutor (research students only):

I have read this form and am happy for it to be considered for ethical approval

Name of supervisor: .....Date:.....

Section D.3 Next steps

[13] For student dissertations and projects, the principal investigator will usually be the student

This signed form with all attachments should be submitted to the appropriate person for review and approval, as indicated on the front sheet of the form.

FOR OFFICE USE ONLY

PART E: OUTCOME OF APPLICATION

Please tick

a) The proposal is satisfactory and is approved as it stands.	
b) The proposal is accepted subject to approval of an NHS, Social Services or other external Ethics Committee (copy to be submitted to SASS when approved)	
c) The proposal cannot be approved and the applicant should submit a new/revised proposal in the light of the comments noted below.	

Comments (for forwarding to the applicant)

Signed .....Date .....

Name (block capitals) ..... Designation .....

A COPY OF THE APPROVED FORM MUST BE KEPT ON FILE.
STUDENTS ON TAUGHT PROGRAMMES AND PGRs MUST SUBMIT A COPY OF THE APPROVED FORM TO THE RELEVANT PROGRAMME SECRETARY.

Appendix A – Text for recruitment of participants through age-related forums, websites and message boards

Hi, my name is Hannah, and I am currently conducting research at Durham University for a PhD exploring the impacts of forced sex or other sexual assault on people aged 60 or over. People over the aged of 60 tend to be ignored in the majority of research, sexual violence campaigns and policies and it is really important that we listen to the experience of people who have experienced this in later life.

I am looking for people aged 60 and over who have experienced this since turning 60. This can be in any context (for example a relationship, a neighbour or someone you didn't know).

I would be really grateful if you would speak to be about the impacts of your experience, what you wanted to happen after, whether you decided to seek any support from specialist rape or other services and the reasons behind your decisions to access or not access support services. I will not be asking for details about the incident itself and you are under no obligation to give any information that you do not want to.

If you are interested in hearing more please email me or reply to this thread and I can send you more information and a list of the interview questions for you to consider.

You can contact me by emailing Hannah.Bows@durham.ac.uk or reply to this thread for more information.

If you don't want to take part but do want information on support available, please contact the rape crisis national Freephone helpline 0808 802 9999, or visit their website http://www.rapecrisis.org.uk/. Alternatively you can contact Women's Aid helpline Freephone 0808 2000 247.

I look forward to hearing from you.

Many thanks,

Hannah

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