

A LIFETIME OF VIOLENCE:

Older women & mental health*

“I lived with my husband for 43 years and I lived in fear every day”
—Judith Arnott¹

“Now at sixty years of age I still have a terrible sense of fear, anger, indignation and overwhelming feelings of injustice toward what happened to my life ...”—Genevieve²

This article looks at some of the particular issues for older women** who have experienced, or who are experiencing domestic and family violence and at the correlation between violence and disability, in particular anxiety and depression. We highlight the phenomenon of life-span violence, including the lifetime impacts of violence experienced in the past, and recent or current violence. Firstly we set the scene with some statistics to establish the extent of violence against older women, and a brief look at the term ‘elder abuse’ and its utility in understanding and responding to violence against older women. We then move to a look at the specific instances of anxiety and depression and issues of diagnosis and response.

What is the extent of domestic and family violence against older women?

Morgan Disney in their study *Two Lives: Two Worlds* report that ‘one in three women currently experiencing domestic violence is over age 45’.³ The *Women’s Safety Survey*⁴ found that 1.2 per cent of women over 55 had experienced some form of partner abuse in the previous 12 months.³

These figures are likely to underestimate the actual extent of violence against older women. A range of barriers including cultural acceptance of violence as part of marriage, the perception that there is no suitable escape path or other alternative to just ‘putting up with it’, reluctance to leave a long-standing connection with home and garden (often consisting of many years of work

and life-long collections of mementos and family artifacts), community networks and non-abusive family all contribute to older women’s reluctance to report violence or attempt to change their living arrangements. The length of time in an undisclosed abusive relationship can make it hard to convince others to take it seriously; that, after many decades of co-habitation, now is the time to do something different like leave, act to prevent the violence or to seek help.⁶ Where issues of mutual responsibility for children impact on younger women’s capacity to leave violence, for older women this may be further compounded by grandchildren and much more complex family connections. Older women are even less likely to have had exposure to contemporary legal, social and community views about what constitutes violence, that it is not acceptable and that it is harmful, so they frequently do not disclose their experiences to anyone who might be able to help.

Yet another issue noted in the literature is the sympathetic response to carers who perpetrate violence against older people in general and older women specifically. Actions of an abusive carer may be excused or legitimised on account of the ‘trouble’ caused by the victim

Elder abuse and adult protective services workers have been trained to identify, assess and intervene in elder abuse cases as instances of caregiver stress, not domestic abuse.’ (Brandl and Raymond, 1997:62) 7,8

This phenomenon will be well-known to women of all ages with disabilities. Women may also be in the position of being the only available carer for an abusive partner or family member and are thereby compelled to provide succour to a perpetrator. Frailty with age and dependence on the perpetrator for care needs, medication and mobility aids, and fear of institutionalization can act as further barriers to disclosure. We can therefore expect to find that the rates of violence against older women are actually a good deal higher than figures quoted here.^{3,10}



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** The age-grouping here is elastic and roughly correlates to peri- and post-menopausal women. Research into violence against older women variously starts with women aged 45 and over, 55 and over, 65 and over, and so on, according to the research aims and themes.

Part of the problem in accurately assessing the extent of violence against older women is the emergence of the term 'elder abuse'.

'Elder abuse' and violence against older women

Much of what we know about violence against older women is hidden or embedded in research into 'elder abuse'. Sexual assault and domestic and family violence are crimes and human rights abuses, regardless of the age of the victim. Co-option of these crimes under a heading of elder abuse when they are perpetrated against older women inadequately signifies the criminal and harmful behaviour of perpetrators and masks the gendered nature of particular forms of violence perpetrated against older women.

The gender-neutrality of service's responses under the rubric of elder abuse mean a lack of sensitivity to gender and can discount or ignore older women's experiences of gender based violence in their youth and fail to provide an appropriate response.⁹

The usefulness of the term in responding to intimate partner or carer violence against older women is limited by its gender-neutral conception and analytical framework. Elder abuse can more inclusively take account of recent or current violence. However elder abuse obscures the specific gendered nature of what may be life-long experience violence against older women; makes it sound like a problem of aging, rather than a continuation of the violence perpetrated against women throughout their lives.^{10,16}

Life-span violence, including the lifetime impacts of violence experienced in the past

Older women's experiences of violence may extend across the life span: injury incurred as a child,

teenager, young woman, or mature woman could be still impacting in later/older years.

It seems counterintuitive to expect that a man who has been abusing his partner for decades will haul up and stop at age 50 or 65 or any other age, because he has aged. It also seems counterintuitive to expect that a woman will cease to feel the impacts of a lifetime of violence once she turns 50 or 90.

Mears and Sargent note in their research with older women that the women were very articulate and consistent in talking about the impact of violence in their younger years on the progression of their lives.¹⁰ 'Many of the women who spoke to us had been living with the lasting effects of this pain every day of their lives for a very long time, for seventy, eighty and even ninety years. Many had never spoken about these experiences before ...'. Likewise in *Speaking the Unspeakable*, in a phone-in against sexual assault, more than half of the respondents were over 40 years of age, with 27 per cent being over 50, and many of these had not ever previously disclosed the sexual violence they endured as much as forty years previously.¹¹ It is no small matter to redress the impacts of decades of violence however the development and progression of disability and mental health conditions rely upon providing conditions for and appropriate responses to disclosure.

Disability, violence and ageing

For women who have lived in abusive relationships for decades the health and social impacts are often chronic and profoundly disabling. In an American study researchers found that: older women were more likely to have experienced violence for a longer time, to be in current violent relationships, and to have health and mental health problems than were the younger women.⁵ Gender-based violence against older women follows similar patterns to that against younger women but with the increased risk

to their health and well-being because of factors like frailty, illness or disability.¹⁰ Australian research by Morgan Disney in 2000 lists impacts reported by the older women they surveyed (in descending order of prevalence): anxiety, depression, changes in eating habits, fears and phobias, panic attacks, alcohol and drug use, sleep disturbance, high blood pressure, heart trouble, and general poor health with frequent illnesses.³ Not surprisingly these impacts largely mirror what the literature reports for younger women. There are, however, amplification differences for older women including the length of time for which they may have endured violence, the compounding effects of untreated or inappropriately treated effects, and the risk that helping professions and services will discount the impacts as being an 'effect of ageing'.⁹

Some effects of ageing can be measured or assessed in terms of change and, as for developmental processes throughout life, these changes are normal. Disability is not an unavoidable effect of ageing. Reading disability as normal in older women could result in service providers, health professionals and others missing, dismissing or minimising vital signs of other conditions and factors, including violence. The notion that older women would naturally experience disabling conditions as a part of ageing can lead to inappropriate attempts to control symptoms, leaving the woman increasingly vulnerable to predation.

Depression & anxiety and older women

To illustrate this point we take a look at depression and anxiety and older women. Depression and anxiety are well recognised as products of violence against women in any age grouping. 'Depression is not normal, at any age' asserts an online information page for older people (at www.psychologyinfo.com/depression/seniors.htm). Whilst it is not normal a significant percentage of older women do experience depression. European research shows that:

*Approximately 10-15% of older people are thought to suffer from depression, and the incidence in nursing homes is much higher (Blazer, 1995). Rates for depression among women are at least two-fold those of men. There are many theories about why this is so, but no definitive answers.*¹³

Brenes et al, in research published in 2005 looking at 'the influence of anxiety on the progression of disability' amongst women 65 and older, cite work by Lenze and colleagues showing that depression is a risk factor for physical disability.¹⁴ More focused research is needed to establish the level of disabling mental, physical and emotional health outcomes for older women who experience violence and perhaps provide some 'definitive' answers.

Brenes and her colleagues conclude from their research that:

anxiety is prevalent and is independently associated with the progression of disability in older adults,

*even after statistically controlling for confounding variables. Women with anxiety symptoms were 28% to 67% more likely to demonstrate greater functional difficulty than women without anxiety.*¹⁴

When we align what we know about, in this instance, anxiety and depression and what is known about the experience of violence a correlation is apparent between violence and disability. The risk of assuming a degree of disability to be consistent with a normal ageing process is that conditions like depression and anxiety are seen to be normal, not treatable, and not generated by sociological conditions that can be changed. Pharmacological and other treatments of the conditions themselves do little to intervene in causal factors and may simply suppress the capacity of an older woman to deal with the reality of her life.

Recent onset or current violence

Recent onset or current violence should not be discounted as a factor for older women. The notion that violence only happens to younger women militates against the recognition of the level of violence for women that may begin only in their older years. In *Two Worlds, Two Lives* Ella tells of marrying for the second time in her fifties and experiencing violence for the first time in her late fifties.^{3,9}

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The Morgan Disney report notes that 'where violence has only started to occur with ageing, dementia, or disability, reactions such as disbelief, shame, guilt, a desire to shield their partner from outside intervention, or not recognising the behaviour as violence, may mean the older person will not disclose'.³

One implication of having endured decades of violence may be that a level of resilience or at least knowing what to expect can provide an element of 'protection' against the shock of a sudden onset of violence. Older women who first experience violence in their older years, or do so after having long suppressed memories of child abuse or sexual assault in their youth, are exposed to the danger described by CNSTAT.

A single episode of victimization can 'tip over' an otherwise productive, self-sufficient older person's life. In other words, because older victims usually have fewer support systems and reserves—physical, psychological, and economic—the impact of abuse and neglect is magnified, and a single incident of mistreatment is more likely to trigger a downward spiral leading to loss of independence, serious complicating illness, and even death.¹⁵

The opportunity for timely, sensitive and well-informed intervention is greater for older women for whom violence is a recent phenomenon. Sensitive and well-informed interventions can also be made for older women for whom the violence is a lifetime experience. The imperative to intervene is amplified by the additional barriers older women face.

Summary

The links here with disability are clear. We don't know how often a fall that results in a broken hip is precipitated by a push or an attempt to flee an imminent episode of abuse, for how many women dementia may be precipitated by early, un-treated violence or decades of continual violence, how often a cardiac arrest is the final escape from violence. A search of Australian literature for this paper failed to produce any research specifically exploring these issues.

We need to recognise and validate the experiences of women who have survived a lifetime of violence. We need to resist the assumption inherent in the term 'elder abuse' that violence is something that happens only when you get older.

Along with the barriers to disclosing violence the invisibility of older women and their specific issues in the community generally and in relation to domestic and family violence (including sexual assault) in particular mean that this area of research needs to be revisited with a significant focus on the voices of older women themselves. Our level of understanding of the extent to which disability is the result of violence can be learned from women who have spent their entire lives dealing with it; the greatly reduced life expectancy for Indigenous women should be taken into account when devising study parameters in this field. Our women elders can provide the long view on this issue.

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