Sexual Abuse - Let's Start The Conversation

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Government of South Australia
Women's and Children's Health Network

yarrowplace rape and sexual assault service

CREATE together

Acknowledgement of Country

We acknowledge Aboriginal people as the First Peoples & Traditional Custodians of Country, throughout Queensland, and particularly the Yugambeh people of this region. We acknowledge & respect First Nations peoples ongoing & deep spiritual connection & relationship to land, air, sea, waters, community & country. We pay our respect to their Elders past, present & emerging.

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- Impact of Trauma Content
- Importance of Practicing Self Care
- Flexible Adult Learning Environment
- Community Prevalence & Lived Experience
- Training vs Therapeutic environment
- Respectful Listening, Communication & Confidentiality

Creating a Learning Environment

Content Warning: this content can be distressing particularly for those with lived experience. **Your wellbeing is important to us.** You are encouraged to take breaks as needed, step out at any time, or access support if required.

Participation is always your choice, & support resources will be available.

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Session Outline

- Statistics & Prevalence
- Increased Risk Groups
- Sexual Abuse & older people
- Key, Values, Myths & Attitudes
- Indicators & starting the conversation
- Best Practice Responses to Disclosures

The Importance of Language

Victim/Survivor

Refers to people who have experienced sexual violence

Individuals may choose either term based on what feels right for them

Offender Terminology – "Perpetrator"

A term used to describe a person who has committed acts of sexual violence

Gendered Language

Sexual violence is influenced by gendered dynamics & power structures

While gender plays a significant role in patterns of harm, we recognise that **people of all genders can experience sexual violence**, and that it disproportionately affects members of the **LGBTQIA+ community**

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yarrow place
rape and sexual assault service

South Australian State-Government service, providing free, confidential, gender-inclusive trauma-informed care for victim-survivors of sexual violence, aged 16 years or above at the time of assault.

Referral Management & Early Response

- 24-hour crisis response & consultation
- Intake & assessment
  Crisis Support
  Risk assessments & Safety Planning
- RMER staff are social workers who triage and respond to referrals

Clinical Forensic Medical Service

- 24-hour crisis response & consultation
- Forensic and Medical Sexual Assault Care
- Clinical Education Sessions
- Sexual Assault Forensic Examiner Training
- Expert medicolegal opinion

Trauma Specialist Counselling

- Individual counselling provided by trauma expert social workers
- Significant other Counselling/support
- Aboriginal cultural Support
- Therapeutic Group Programs
- Metro (outreach), Regional & Telehealth options

Youth Counselling Programs

- Young people 12-25 Under guardianship
- Intensive Therapeutic Care Program
  Risk of or experiencing Child Sexual Exploitation
- My Place
  Pregnant and at risk of having child removed
- Training Looking Beyond Behavior

Education, Training & Community Engagement

- Lived Experience Advocacy Committee
- Service Design improvements
- Lived experience in training
- Statewide training packages; public, tailored, online & in person options
- Advocacy, Public Policy & Research

Approximately 1 in 5 women and 1 in 16 men have experienced sexual assault since the age of 15 in Australia (PSS, 2021-22). 1 in 2 LGBTQIA+

87% of sexual assaults were perpetrated by a person known to the victim / survivor (ABS ,2021-22)

74% of women sexual assault victim-survivors do not immediately realise they have been sexually assaulted (ABS, 2021)

92% of women who experienced sexual assault did not report the incident to police.

Only 23% of women were physically injured in the most recent incident of sexual violence (PSS, 2021-22).

Studies published in Australia, Canada, UK & USA from 1999-2014 estimate that approx. only 5% of police reports were confirmed false.

Commonly held Myths/Misconceptions:

Myth: Older people don’t experience sexual assault.
Fact: Sexual assault can occur at any age.

Myth: Sexual assault of older people is rare.
Fact: Although its is underreported. Prevalence is high.

Myth: Perpetrators are usually strangers.
Fact: Perpetrators are often known to the victim, including partners, family members, carers, or other residents.

Myth: People with dementia or cognitive impairment are unreliable witnesses.
Fact: They can still disclose abuse and should always be taken seriously.

Myth: Older people cannot be sexually assaulted if they are no longer sexually active.
Fact: Sexual assault is about power, control, and violence—not sexual desire.

Myth: There will always be obvious physical injuries.
Fact: Most victims have no visible injuries. Most survivors will freeze or fawn meaning no physical force is needed.

Myth: If they didn't report immediately, it probably didn't happen.
Fact: Delayed disclosure is common due to fear, shame, dependence, or cognitive impairment.

Impacts of Myths

- Victim/survivors often don’t recognise/identify their experience as sexual violence
- Responsibility & or blame is placed onto the victim/survivor
- Victim/survivors credibility is questioned while perpetrators' actions are excused or minimised
- Society assumes that older people don’t/can’t experience sexual violence
- Creating a silencing effect
- Reduced community understanding, awareness & concern
- Ageist assumptions can lead to poor responses, inadequate investigations, reduced access to justice & support

Overall, this impacts/delays healing & recovery by causing victim/survivors to internalise blame & shame, rather than recognising that responsibility belongs to the person who used violence.

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Increased Risk Groups

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- Aboriginal & Torres Strait Islander people
- CALD
- Refugee & Asylum Seekers
- People with a Disability
- LGBTQIA+ Community
- Older people
- Young Women
- Previous trauma
- People living with mental health illness
- Sex Workers
- Rural & Remote

Increased risk is linked to systemic failures, social marginalisation & a perpetrator's choice to exploit/abuse power

Prevalence for Older Women

Sexual assault of older people is widespread, under-reported & shaped by lifelong patterns of violence, gender inequality, & ageism - *meaning figures are likely higher*

- People in residential aged care face a substantially higher risk of assault than people living in the community
- **50 sexual assaults** occur each week nationwide in residential aged care settings
- Most victims are women living with dementia
- Many older victim-survivors are long-term victims of domestic family violence
- Delayed disclosure is common, with many older women disclosing years or decades after an assault.

Royal Commission into Aged Care Quality and Safety. (2020, October 22).

Risk Factors for Older Women

- **Ageism & desexualisation** make sexual violence against older women invisible, leading to disbelief and systemic inaction
- **Sexual harm** is often not believed to occur in later life, resulting in missed warning signs & under-reporting
- **Sexual assault** of older adults is frequently minimised or dismissed due to age-based assumptions
- **Generational attitudes** may prevent sexual violence from being recognised or named as abuse, particularly in intimate or caregiving relationships
- **Women with dementia & cognitive impairment** face increased risk, as disclosure may be limited & credibility questioned. They are deliberately targeted exploiting their perceived or assumed lack of memory or credibility

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Potential Indicators

Context should always be taken into consideration. Indicators may, or may not be, a sign of sexual violence.

How To Ask?

k to the person in a private, quiet setting away
family members, partners, caregivers & other
ents if possible & appropriate.

When starting the conversation, it's important to approach the topic with sensitivity, clarity, & without assumptions. A trauma-informed approach emphasizes safety, respect, & giving the person control over what they choose to share.

Start with: *I have noticed changes within you. (Reflect the change or behaviours you have noticed) Is everything ok?*

You might continue with something like:

- *"Can we talk about your safety and wellbeing. I ask everyone these questions because abuse can happen to people of any age."*
- *"Is there anyone who has touched you in a way that made you feel uncomfortable or without your permission?"*
- *"Has anyone ever made you do something sexual that you didn't want to do?"*

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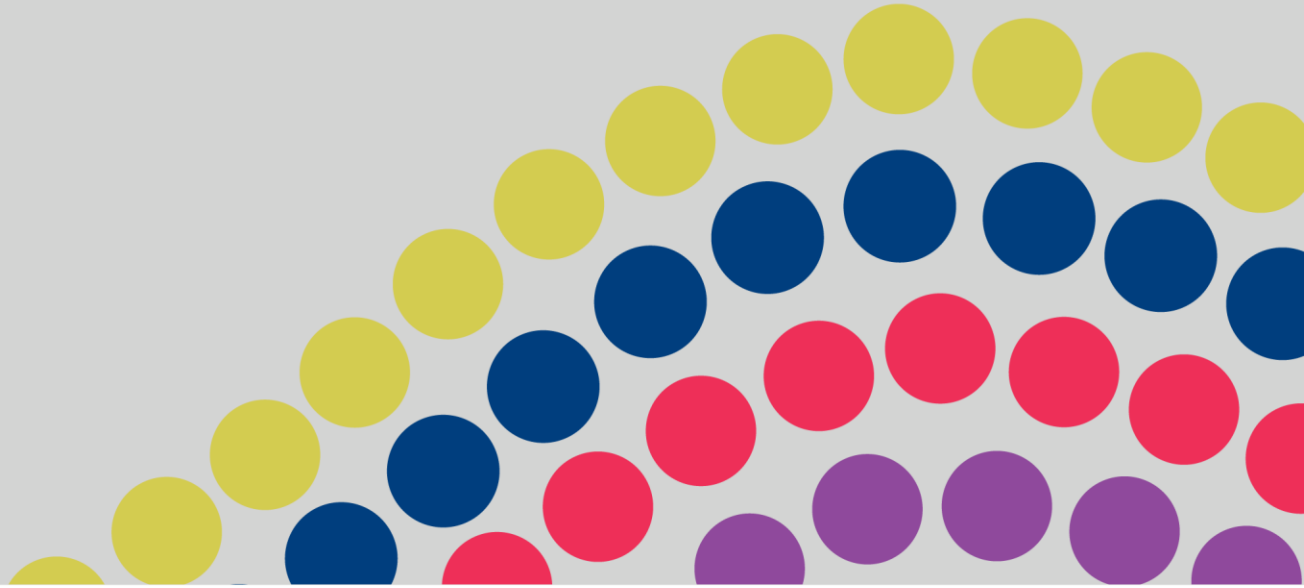
*"If you don't have the courage to **ask**, I won't have the courage to **tell**"*

Lily Consumer Advocate



Examples of Disclosures

- "A monster came into my room last"

a

- "I have pain in my private area and its hurts to go to the bathroom"

b

- "I think he took advantage of me"

c

- "He touches me for a long time when he showers me"

d

Complexity factors

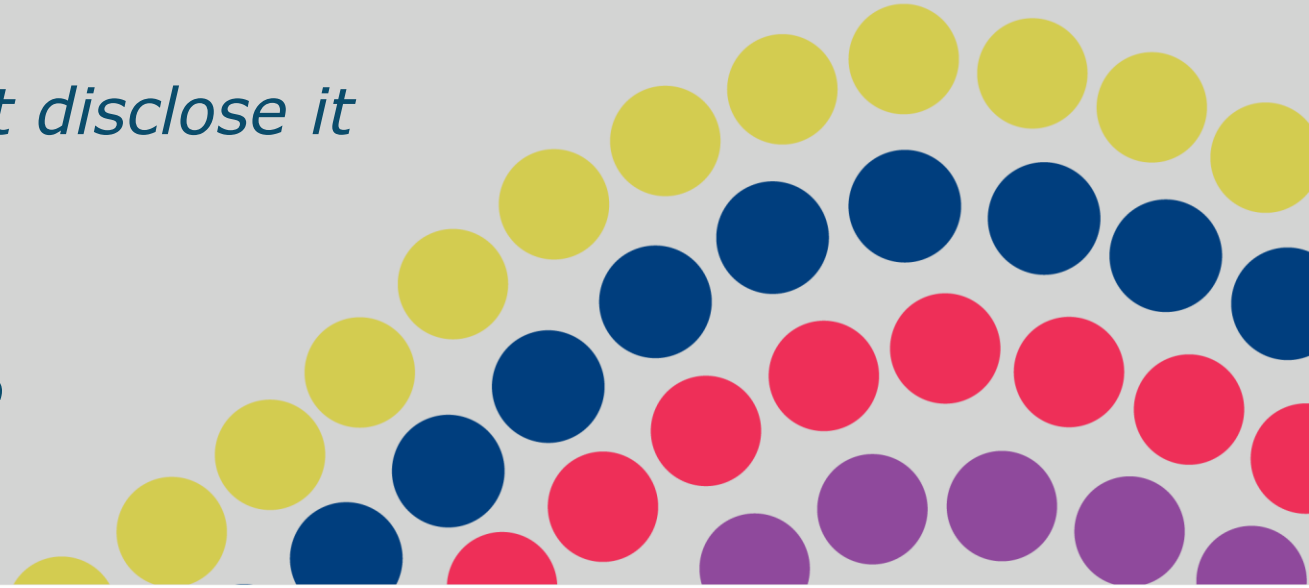
- Home vs Aged Care
- MH/Cognitive Conditions
- Physical Conditions
- Collateral

"When I was 13 years old, I told my friend about my family GP sexually abusing me. She told me not to tell anyone, as she thought it would be too upsetting for my mother who thought the world of him; he was like a trusted family member".

So I didn't tell.

The abuse continued and I didn't disclose it again, until my late 50s".

Karen Consumer Advocate



"Although they may not remember me, I remember every single interaction with every person. The good ones give me hope for better outcomes and the bad ones keep me awake at night. I will never forget the words that were said to me".

Amanda
Consumer Advocate

Helpful Responses

Communication Considerations

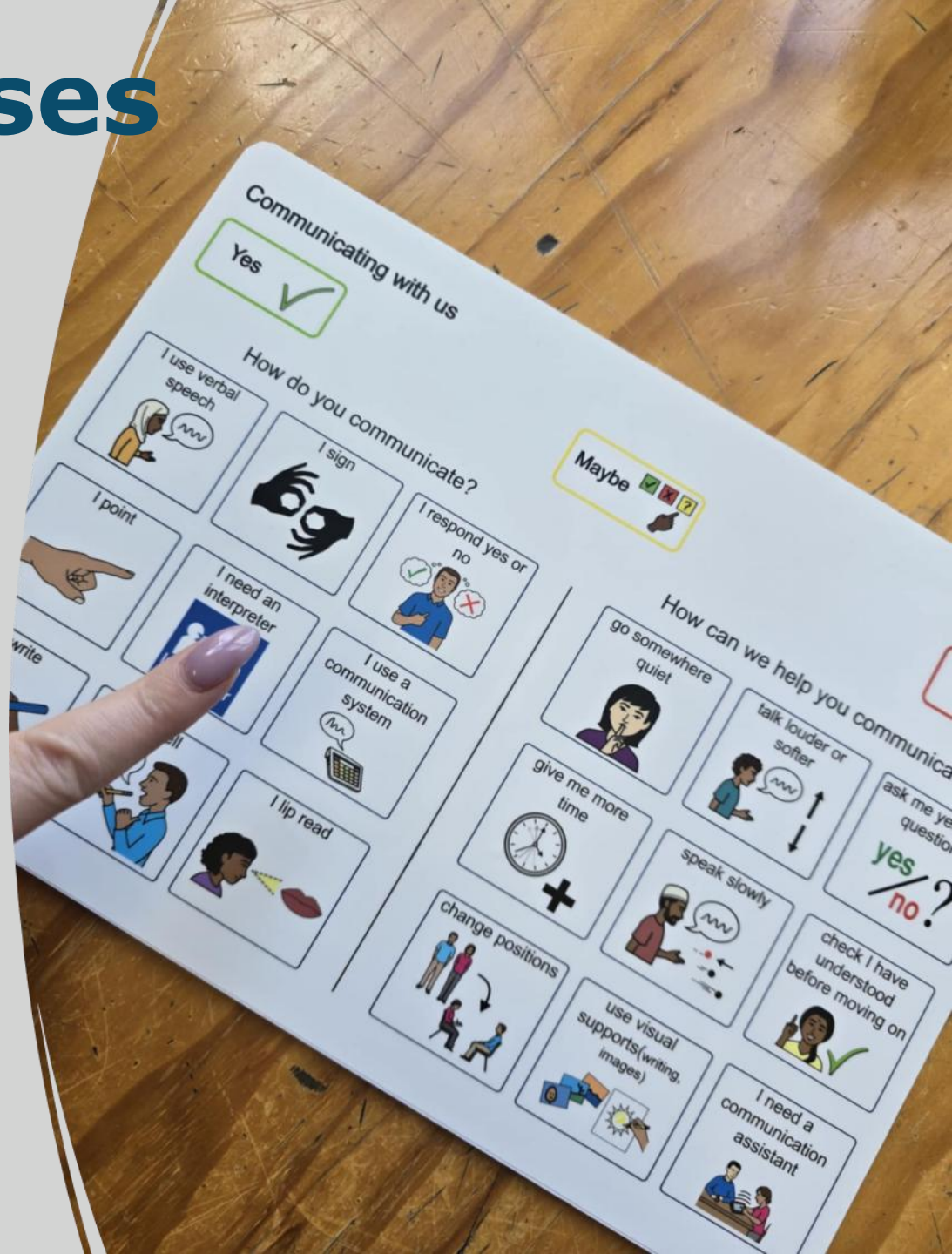
A disclosure may be verbal, behavioural, emotional, or conveyed through changes in mood, behaviour, or functioning.

Use communication strategies that support understanding:

- Speak slowly & clearly
- Use simple, concrete language
- Ask one question at a time
- Allow time for responses
- Reduce distractions & ensure privacy

Listen, Believe & Validate

- Communicate belief & validate the disclosure
- Avoid questioning the person's credibility
- Listen without judgment
- Stay calm; avoid reactions of shock, disgust, surprise
- Validate their experience, responses & feelings



The Victim/Survivor is not Responsible

- Don’t minimise or blame the victim/survivor because of confusion, memory, impairment, or behaviour
- Avoid placing responsibility on the person to have prevented/reported the abuse
- Reinforce that responsibility lies entirely with the offender
- Gently challenge any self-blame from the victim/survivor
- “You did not choose to be hurt in this way. This was not your decision or your fault.”

Create a Sense of Control

- Avoid speaking to only to family or caregivers instead of the person
- Let the person share at their own pace
- Determine support needs: recent vs historical assault
- Avoid invasive questions or asking for details

Provide Information & Support Decision-Making

- Be guided by what the person wants & needs whilst considering decision-making capacity
- "*What is the best way I can support you right now?*"
- Offer possible options/supports, in clear, simple & manageable way but leave decisions to them (forensic examination, medical treatment & emotional support).
- Allow time & space for decisions to be made

Promote Hope & Recovery

- Without minimizing the abuse, communicate that healing is possible
- Avoid pressuring the person to "be okay" or move on or that the person won't be as impacted.
- Emphasise that recovery is individual & non-linear
- Support is available for everybody

Respect, Dignity & Confidentiality

- Keep their disclosure confidential & seek consent where possible before involving others
- Avoid promising confidentiality when mandatory reporting, organisational policies or safeguarding applies
- Support the person to understand decisions made on their behalf
- Collaborate with specialist services & support networks if suitable; Family, police, GP, ASU, Aged Care & NDIS

Risk & Safety Considerations

- Immediate physical injuries (strangulation)
- Self-harm, suicidal ideation, psychological distress
- Risk of further assault/abuse (DFV context or resident)
- Cognitive impairment affecting ability to recognise/report
- Vulnerabilities due to frailty, disability, or communication barriers
- Risk of neglect or withdrawal of care due to disclosure of carer assault

Closing Acknowledgement

We acknowledge the heavy & sensitive nature of today's content. Engaging with topics related to sexual violence can be challenging and may bring up emotional, physical, or personal responses. We encourage you to prioritise self-care this afternoon in ways that feel supportive for you, and to reach out to, yarrow place, 1800RESPECT, Fullstop Australia, trusted supports, colleagues, EAP or other professional services as needed.

Thank you for your engagement, compassion, and commitment to this important work.