Domestic abuse and older women: exploring the opportunities for service development and care delivery

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Abstract

Purpose – *The purpose of this paper is to explore the impact of domestic abuse on the health and lives of older women.*

Design/methodology/approach – *A qualitative research design was used and data were collected using in-depth interviews with 16 older women who had experienced domestic abuse. The interviews varied between one and two hours in length and, with the participant's permission, all of the interviews were audio recorded and transcribed verbatim. Analysis was undertaken utilising an iterative approach. In the present study all data were manually indexed and coded.*

Findings – *The findings of this study illustrate that the consequences of domestic abuse for older women are far reaching, impacting significantly on the long-term health and emotional wellbeing of those affected. This paper also highlights that there is currently little available data regarding older women and domestic abuse within the particular context of health. This is increasingly being recognised as a significant deficit in awareness and understanding within society as a whole and, more particularly, for those responsible for support and care provision. Existing policy in this field and the implications for service development are also considered.*

Research limitations/implications – *This is a small scale study and therefore there are limitations in terms of generalisability.*

Originality/value – *This paper discusses the specific issues that arise for older women who have experienced domestic abuse within the particular context of health.*

Keywords *Domestic abuse, Older women, Service provision, Health community, Personal health, Policy initiatives*

Paper type *Research paper*

Background

Domestic abuse is a complex and largely hidden phenomenon. It has been defined as encompassing a wide range of harms including physical, emotional, sexual and financial of people who are or have been intimate partners (Department of Health, 2000a). The consequences of domestic abuse are far reaching, impacting significantly on long-term health and emotional wellbeing of those affected (McGarry, 2008).

Historically, a number of cultural and social factors, i.e. domestic abuse has only relatively recently been viewed as a crime in the UK, has led to many older women ''suffering in silence'' (Blood, 2004). Many surveys and studies have excluded women over the age of 59 years (Women's Aid, 2007) further reinforcing the view that domestic abuse only affects younger women and thereby effectively excluding and ignoring the particular experiences of older women.

Additionally, there are a number of other factors which contribute to this deficit in current knowledge, for example, barriers to disclosure (Acierno *et al.*, 2001) and the failure of health and social care professionals to recognise domestic abuse as occurring in this age group (Women's Aid, 2007). This again illustrates the stereotypical images that exist supporting the

view that domestic abuse mainly affects younger women. Moreover, it has been highlighted that the way in which domestic abuse has been poorly defined among older women or subsumed under the generic term of elder abuse homogenises older people rather than recognising individual differences, including gender (Hightower, 2002).

The blurring of the boundaries between elder abuse and domestic abuse have been highlighted elsewhere with Scott *et al.* (2004) describing the ''ideological gulf'' between those working in domestic abuse services and those providing aged care. It is argued that this may have occurred as a result of older women's perceptions of themselves and service perspectives on domestic abuse (Morgan Disney and Associates, 2000). For example, Scott *et al.* (2004) suggest that while domestic abuse is viewed as a gendered abuse of power, in later life domestic abuse is treated as a ''sub-set'' of abuse against older people and, therefore, the particular experiences of older women and the particular difficulties that they face are ignored. Moreover, the presumptions that have pervaded elder abuse, and which further ignore the significance of power and gender (Aitken and Griffin, 1996; Penhale, 1999), fail to appreciate the significance of the underlying complexities of ''the nature of power relations within abusive relationships in later life'' (Penhale, 1999).

From a care provision perspective, women's refuges and other domestic abuse services may not be appropriate for older women for a number of reasons such as a lack of facilities for those with disability and mobility issues, and an absence of the specialised support that older women may need (Women's Aid, 2007).

While research in this area may be scarce the work that has been undertaken to date (Blood, 2004; Mouton *et al.*, 2004) would suggest that domestic abuse is both a significant and an under recognised phenomenon which has a wide ranging impact on the lives of older women. It also suggests that older women's experiences of domestic abuse are markedly different from those in younger age groups and that these differences have not been adequately acknowledged or accounted for (Blood, 2004). This pilot study has sought to explore this gap from the particular perspective of health care delivery and provision of care.

Aim

The overall aim of this study, therefore, was to explore older women's experiences of domestic abuse and to examine the particular impact on the health and lives of older women affected by domestic abuse. In so doing it was also anticipated that particular support and service development issues would be identified.

Method

A qualitative design was used and data were collected using in-depth interviews with 16 older women (age range 63-79 years) who had experienced domestic abuse. Potential participants were identified through a counselling service and local media. An aide memoire was utilised as a guide. Owing to the sensitivity of the subject matter, all of the interviews were led by the participants in terms of disclosure of issues. The interviews varied between one and two hours in length and, with the participant's permission, all of the interviews were audio recorded and transcribed verbatim.

Data analysis

All transcribed interviews were reviewed against the original recordings to establish accuracy. Analysis was undertaken utilising an iterative approach (Hammersley and Atkinson, 1995) and was informed by the analytic hierarchy model (Ritchie and Lewis, 2003). In practice, this entailed the identification of emerging themes and concepts and the recording of such. Identification of gaps in the data and areas for further exploration and clarification were highlighted and pursued in subsequent interviews. In this study, all data were manually indexed and coded.

Ethical considerations

Ethical approval was granted by the local research ethics committee. An information sheet outlining the purpose of the study was given to each participant prior to the interviews taking place. All participants were informed of their right to withdraw from the study at any point and that confidentiality would be maintained at all times. In addition, information regarding counselling and support services was made available to all participants.

Findings

Stripped of identity: the impact of domestic abuse on the lives and health of older women

The impact of domestic abuse has been well documented within the literature and has the potential to significantly affect the short and long-term physical and psychological health status of women (Women's Aid, 2007). In this study, the long-term consequences of physical abuse on health in later life was identified as a particular issue for a number of participants:

> He was extremely abusive and he put me into the hospital quite few times. The consequences on my health now [. . .] I have had a major bone problems, and I had to have an operation on my spine, and I am questioning whether that was to do with the beatings. I've got arthritis and I had a lots of broken bones when he was doing this, so whether that impacted [. . .] I'm sure that this possibly did impact up on me now [. . .] Like now I can hardly walk, and I have to go in a wheel chair to go about (Participant 1: 63 years).
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> I' m waiting for a hearing aid and now [. . .] I got severely bashed on my ear, and I'm told that I can't hear at all in this ear, and I've been told that it is perforated eardrum (Participant 8: 76 years).

Women who have experienced domestic abuse generally are also at an increased risk of experiencing mental health problems which include depression and suicide (Cohen *et al.*, 1998). Many of those in this study had experienced a number of psychological problems, both at the time of the abuse and also in later life, for example panic attacks and acute anxiety:

> But in enduring this period [of abuse] I've had lots and lots of mental health problems. I've been in and out of the hospital having violent attacks of acute anxiety they said, that is what they call them [. . .] they said it was acute anxiety, because I didn't have the tools to manage what he was doing to me (Participant 1: 63 years).
>
> The long-term impact on my health has been depression [. . .] I had it then when all that was going on and now for ten years [. . .] nearly twelve years (Participant 7: 75 years).
>
> Because I don't want to be out more than two three hours and then I've got to get back [. . .] I've got to get back [. . .] don't ask me why [. . .] I've got to get back [. . .] (Participant 2: 71 years).

Furthermore, older women who have experienced domestic abuse at an earlier time in their life, and which may remain unresolved in later life also experience a number of emotional issues relating to their experiences such as frustration, anger, helplessness, hopelessness and low self esteem (Wolkenstein *et al.*, 1998). Many older women in this study encountered these feelings and in many instances were unable to disclose this to others:

> Oh God, [. . .] but obviously, it affects you in a horrible way [. . .] you feel worthless, you feel useless, and you feel like you don't get anything right [. . .] your confidence and your self esteem [. . .] you don't have any [. . .] and it impacts you on many levels [. . .] many levels (Participant 1: 63 years).
>
> And your self esteem [. . .] and you just feel that you are totally and utterly stripped of any identity so it is like building another self when you finally get away (Participant 4: 76 years).

Moreover, participants in this study also spoke of the impact of the consequences of abuse on family relationships, particularly in terms of relationships with their children. This is a particularly important issue, especially in later life where family support may be most needed:

> Well [. . .] [daughter] was oldest and is mentally scarred, she will never ever live forward and [son] and [son] because they have been there all the time I mean my [son] was only two and a half so can only remember vaguely (Participant 7: 75 years).

> I find peace [names a place she visits with daughter]. I think my daughter knows it all [. . .] I don't know. She feels the same [. . .] I said to her, do you know [. . .] I said [. . .] you are a different person, and she said yeah and you are mum. We laugh don't we [. . .] (Participant 2: 71 years).

Giving permission: potential barriers to reporting domestic abuse

A number of barriers in the reporting of domestic abuse by older women have been highlighted (Beaulaurier *et al.*, 2007). In this study, for example, study participants spoke of how historically the home was perceived as private and ''what went on there was behind closed doors''. Study participants also felt a sense of shame or embarrassment and as such kept their experiences ''hidden'' from family, friends and neighbours:

> It was behind doors a lot, you know what I mean, like mine was, and in them days, years ago, there was nothing at all for us to turn to, you know (Participant 8: 76 years).
>
> No I kept it [the abuse] to myself. Nobody understands why you keep it quiet and make excuses, but you're embarrassed and you love him (Participant 11: 66 years).

Moreover, study participants also spoke of the absence of formal or informal networks in terms of potential support:

> There was nothing for you [. . .] and my parents would say ''you make your bed then lay there'' really [. . .] so I got no support [. . .] so I think that is the problem and which made me accept that [the abuse] in a very funny kind of a way (Participant 1: 63 years).
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> No refuges or whatever, not in those days, that's what I'm saying. You couldn't say to someone please take me, there just wasn't anywhere to go (Participant 2: 71 years).
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> There was no point in calling the police, they'd come and he'd be in the cells and the next morning home again and I'd get it for reporting it (Participant 8: 76 years).

In addition the feelings of shame or embarrassment experienced by women during the occurrences of abuse often pervaded into later life. In this study for example, one participant spoke of how she felt unable to speak directly to her doctor (GP) about her experiences, but rather handed him a note explaining her situation. Another participant spoke of how she felt that older women needed to be ''given permission'' to speak out and to understand that it was acceptable to disclose domestic abuse:

> So I wrote a little note [about previous domestic abuse] and went to see my GP. Gave him this note [. . .] I just put that I feel rather low, and wonder if counselling would help. And he looked at me and said: umm [. . .] yes (Participant 5: 64 years).
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> I think it is the ''hiddeness'' of it that is problem actually out of it [. . .] I think that needs to stop [. . .] I think we've got to give permission or try to get older women to realise that it is very wrong that they have been abused (Participant 1: 63 years).

Should be more information: service provision for older women

From a contemporary perspective, there is little evidence from within the UK regarding access to services for older women who experience abuse. However, a recent US study has identified that older women were not always aware of the existence of services (Beaulaurier *et al.*, 2007). This was clearly echoed by older women in this study who found out about services indirectly or felt that the services available would not meet their particular needs, for example they felt that the focus was towards younger women with children:

> I just think there should be more information. I was very grateful to pick up this leaflet [local counselling service for older women] there again it was in a mental health waiting room rather than a doctor's surgery. It was for older women and that was the only advert that I have ever seen. Most of it [domestic abuse services] applies to the young age groups because you just wouldn't go there as a person over fifty. I still don't know whether it is just help and support for younger women with younger children [. . .] there should be more out there and people made aware of the needs of older women (Participant 5: 64 years).
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> I don't know [. . .] just I just couldn't cope last year [. . .] I was crying all the time. I went to [name of venue], there was a woman there [. . .] she was a nurse and she said to me have some counselling [. . .] honestly, it was the best thing. It really, really helped me (Participant 16: 78 years).

> I didn't talk about it [domestic abuse] to anyone and I was sitting on the bus [recently] and there was an advert for counselling [for domestic abuse] Have you this and that? And I thought that's me, and here we are (Participant 10: 74 years).

Discussion

It is recognised that this was a small-scale study, which raises questions about the generalisability of the findings. However, the aim was not to make empirical generalisations but to explore older women's experiences of domestic abuse with a view to opening the dialogue regarding the potential development of services and care for older women and as such the study achieved its aims.

As the background to this study and the findings have illustrated, to date there has been little exploration of the particular situation and specific health needs of older women in the UK who have experienced domestic abuse (Blood, 2004). Some of the key reasons for this omission have been clearly articulated in this study and unmistakably incorporate a number of potential barriers to disclosure (Acierno *et al.*, 2001). Zink *et al.* (2005) have also highlighted that while there are similarities in terms of the reasons for non-disclosure to health care professionals for both younger and older women, older women were also bound by the ''traditional mores of their time'', for example beliefs about privacy in the home and a lack of awareness about the available support mechanisms. Moreover, Mears (2002) also emphasised that older women are reticent about reporting abuse through fear of the consequences in terms of abandonment and poverty.

These themes were echoed in our own study and as illustrated earlier draw attention to a key point in terms of the wider issues of raising awareness among older women of the support and services that are available to them. This relates to the need for information and resources to be targeted to areas where they are visible to older women, for example GP surgeries or other public areas. The study has also underlined the specific health impact of domestic abuse for older women. This includes the effects of long-term trauma alongside mental health problems, for example depression, anxiety and other mental health issues, increased morbidly and mortality (Women's Aid, 2007; Scott *et al.*, 2004) and the subsequent long-term consequences on family relationships and services.

The findings of the study also illustrate that older women felt that there were few mechanisms through which to gain formal recognition and support. From a policy perspective within the UK there have been recent calls for routine enquiry regarding domestic abuse to be incorporated into particular health and social care encounters, for example antenatal care (Department of Health, 2000a). However, while this is an important initiative it still fails to acknowledge or signpost the issues of domestic abuse within the particular context of older women.

Moreover, within the literature there has been considerable debate regarding the effectiveness of screening for domestic abuse across all age groups (Feder *et al.*, 2009; Taket *et al.*, 2004) including routine screening and case finding. To date, the findings of these studies are not unequivocal and again few have specifically focused on the particular issues that potentially impact on screening for older women. Where this has been explored particularly within the context of older women, a range of innovative initiatives have been highlighted, though these have mostly occurred in the USA and North America (Scott *et al.*, 2004). Furthermore, initiatives of any kind require agencies and individuals to recognise the issues surrounding domestic abuse and older women in the first instance before they can be effective.

A number of studies have considered the impact of training or education initiatives for health and social care professionals in the identification and management of domestic abuse generally (Cole, 2000; Taket *et al.*, 2003). A study conducted in the USA among health and social care workers from a number of professions concluded that training exerted an impact in terms of increased knowledge of domestic abuse (Harwell *et al.*, 1998). However, the study also found that professionals remained reticent about actually approaching this issue with women. Additionally, Moore (1998) emphasised that the effectiveness of identification

was dependent upon the area within which professionals were working, for example nurses in hospital settings were less likely to ask about domestic abuse because of fear of offending patients and others. They were also least likely to have had education and training related to domestic abuse compared with other disciplines. Within the particular context of older women and domestic abuse, given the number of older people who access hospital services, arguably this represents a significant deficit in knowledge and training and an omission in current care provision.

However, a huge barrier in effective recognition and reporting, as highlighted earlier remains in that health and social care professionals and commentators continue to hold stereotypes and assumptions regarding domestic abuse as a phenomenon that is not encountered by older women or there is continued confusion regarding the difference between elder abuse and domestic abuse. As McCreadie (1996) suggested, the discourses on elder abuse and domestic abuse have evolved as separate entities, and as such the commonalities, consequences and implications for service provision have been neglected.

A recent European report (Nagele *et al.*, 2010) has also identified that domestic abuse education regarding older women should be embedded within general domestic abuse training programmes as a whole in order to ensure that professionals are able to recognise and take appropriate action.

English social policy in this field to date has largely focused on abuse of older women within the context of *No Secrets* (Department of Health, 2000b). *No Secrets* (2000a) was published by the Department of Health in 2000 and provides guidance to professional agencies on the development and implementation of policies and procedures to protect vulnerable adults (Blood, 2004). Within *No Secrets* abuse is subsumed within vulnerable adult protection and as such it may be argued that the emphasis is towards formal rather than domestic circumstances. Moreover, the lack of conceptual clarity that currently exists with regard to the terminology used, for example how ''vulnerable'' is defined results in a lack of specific guidance to professionals. As such, Blood (2004) argues that this ''narrow definition'' of vulnerable could discourage older women from seeking support of services. Blood (2004) further argues that whilst *No Secrets* partially bridges the gap between elder abuse and domestic abuse, the failure to fully articulate the need for services to recognise and work in a more cohesive way does little to address the gaps in working practices between different professional groups.

From this perspective, Phillips (2000) argues that the particular issues for older women who have been subject to domestic abuse need to be brought into ''the mainstream'' policy debates rather than remaining a hidden phenomenon. *No Secrets* is currently undergoing a review and the findings will need to be scrutinised in terms of the contemporary developments in this field.

However, if unresolved, the lack of conceptual clarity at a policy and organisational level that has existed to date has the potential to exert significant consequences in terms of the continued paucity of service provision for older women. Scott *et al.* (2004), for example highlight the need for development in terms of multi-agency working and that professionals, as the ''gatekeepers of services'', need to be able to recognise and respond appropriately to such situations. They further suggest integrated referral systems and cross-training may go some way to bridging the gaps between domestic and elder abuse services. More recently, this has been echoed even more strongly with Nagele *et al.* (2010) highlighting ''insufficient and inadequate interagency cooperation'' and the need to clearly define roles and responsibilities of different agencies alongside interagency training.

In addition, Scott (2008) has identified that older women were ''far more visible on the research agenda'' than when their earlier literature review was undertaken in 2002-2003. However, while older women may be more visible in terms of the literature, a clear gap still remains in terms of how service provision and care should be developed in practice for older women, for example the development of specific screening initiatives. It is, therefore, suggested that further research is now needed to address this deficit.

Conclusion

The limited research that has been undertaken to date and the existing literature in this field highlights that domestic abuse exerts a significant impact on the health and lives of older women (Mears, 2002). For older women, there are additional challenges in accessing services and receiving appropriate support.

The health and social care community as a whole have a central role in both identifying domestic abuse and understanding the particular experiences and needs of older women affected by domestic abuse. A pivotal part of this challenge, therefore, lies firstly in recognising that domestic abuse among older women is a substantial issue at an organisational and service level and secondly in developing services and support which are currently largely absent, to meet the particular needs of this group.

References

Acierno, R., Gray, M., Best, B., Resnick, H., Kilpatrick, D., Saunders, B. and Brady, K. (2001), ''Rape and physical violence: comparison of assault characteristics in older and younger adults in the national women's study'', *Journal of Traumatic Stress*, Vol. 14 No. 4, pp. 685-95.

Aitken, L. and Griffin, G. (1996), *Gender Issues in Elder Abuse*, Sage, London.

Beaulaurier, R., Seff, L., Newman, F. and Dunlop, B. (2007), ''External barriers to help seeking for older women who experience intimate partner violence'', *Journal of Family Violence*, Vol. 22 No. 8, pp. 747-55.

Blood, I. (2004), *Older Women and Domestic Violence: A Report for Help the Aged and Hact*, Help the Aged, London.

Cohen, D., Llorente, M. and Eisdorfer, C. (1998), ''Homicide-suicide in older persons'', *American Journal of Psychiatry*, Vol. 155 No. 3, pp. 390-6.

Cole, T. (2000), ''Is domestic violence screening helpful?'', *Journal of American Medical Association*, Vol. 284 No. 5, pp. 551-3.

Department of Health (2000a), *Domestic Violence: A Resource Manual for Health Care Professionals*, Department of Health, London.

Department of Health (2000b), *No Secrets: Guidance on Developing and Implementing Multi-agency Policies and Procedures to Protect Vulnerable Adults from Abuse*, HMSO, London.

Feder, G., Ramsay, J., Dunne, D., Rose, M., Arsene, C., Norman, R., Kuntze, S., Spencer, A., Bacchus, L., Hague, G., Warburton, A. and Taket, A. (2009), *How Far Does Screening Women for Domestic (Partner) Violence in Different Health-care Settings Meet Criteria for a Screening Programme? Systematic Reviews of Nine UK National Screening Committee Criteria*, University of Bristol, Bristol.

Hammersley, M. and Atkinson, P. (1995), *Ethnography: Principles in Practice*, 2nd ed., Tavistock, London.

Harwell, T., Casten, R., Armstrong, K., Dempsey, S., Coons, H. and Davis, M. (1998), ''Results of a domestic violence training program offered to the staff of urban community health centers'', *American Journal of Preventive Medicine*, Vol. 15 No. 3, pp. 235-42.

Hightower, J. (2002), ''Violence and abuse in the lives of older women: is it elder abuse or violence against women? Does it make any difference?'', Background paper for INSTRAW Electronic Discussion Forum – Gender Aspects of Violence and Abuse of Older Persons, available at: www.un-instraw.org/en/docs/ageing/Jill_Hightower_discussion_paper.pdf

McCreadie, C. (1996), *Elder Abuse: Update on Research*, Age Concern Institute of Gerontology, Kings College, London.

McGarry, J. (2008), ''Older women and domestic violence: defining the concept and raising awareness in practice'', *Nursing Older People*, Vol. 20 No. 6, pp. 10-11.

Mears, J. (2002), *'It's My Life Now': Older Women Speak Up about Domestic Violence*, University of Western Sydney, Sydney.

Morgan Disney and Associates (2000), *Two Lives – Two Worlds: Older People and Domestic Violence*, Partnerships Against Domestic Violence, Canberra.

Mouton, C., Rodabough, R., Rovi, S., Hunt, J., Talamantes, M., Brzyski, R. and Burge, S. (2004), ''Prevalence and 3-year incidence of abuse among postmenopausal women'', *American Journal of Public Health*, Vol. 94 No. 4, pp. 605-12.

Nagele, B., Bohm, U., Gorgen, T. and Toth, O. (2010), *Intimate Partner Violence Against Older Women – European Summary Report*, Zoom-prospektive, Gottingen.

Penhale, B. (1999), ''Bruises on the soul: older women, domestic violence and elder abuse'', *Journal of Elder Abuse and Neglect*, Vol. 11 No. 1, pp. 1-22.

Phillips, L. (2000), ''Domestic abuse and aging women'', *Geriatric Nursing*, Vol. 21 No. 4, pp. 188-95.

Ritchie, J. and Lewis, J. (2003), *Qualitative Research Practice: A Guide for Social Science Students and Researchers*, Sage, London.

Scott, M., McKie, L., Morton, S., Seddon, E. and Wosoff, F. (2004), *Older Women and Domestic Violence in Scotland. . .and for 39 years I got on With It*, NHS Health Scotland, Edinburgh.

Taket, A., Wathen, N. and Macmillan, H. (2003), ''Should health professionals screen all women for domestic violence?'', *PLoS Medicine*, Vol. 1 No. 1, pp. 7-10.

Women's Aid (2007), *Older Women and Domestic Violence: An Overview*, Women's Aid, London.

Zink, T., Fisher, B., Regan, S. and Pabst, S. (2005), ''The prevalence and incidence of intimate partner violence in older women in primary care practices'', *Journal of General Internal Medicine*, Vol. 20, pp. 884-8.

Further reading

Brandl, B. and Horan, D. (2002), ''Domestic violence in later life: an overview for health care providers'', *Women and Health*, Vol. 35 Nos 2/3, pp. 41-54.

Wolkenstein, B.H. and Sterman, L. (1998), ''Unmet needs of older women in a clinic population: the discovery of possible long-term sequelae of domestic violence'', *Professional Psychology: Research and Practice*, Vol. 29 No. 4, pp. 341-8.

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