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Why domestic abuse and not elder abuse?

Stereotypical views of old age, along with ageist discourses associated with ‘decline’ and ‘disengagement’, have served to marginalise older people from mainstream society (Biggs & Powell, 2001; Cumming & Henry, 1961). A pervasive structural ageism places less value on older people in comparison to their younger counterparts and has in part, contributed to the systemic invisibility of older people as victim-survivors of domestic abuse. As a consequence, when compared to other age groups, there is a paucity of knowledge about the lived experiences of older victim-survivors of intimate partner violence (IPV) and their help-seeking experiences (Wydall & Zerk, 2017; McGarry & Ali, 2019; Wydall, Clarke, Williams, & Zerk, 2019).

As Mansell and Beadle-Brown (2009, p. 34) note, although ‘older people dominate the abuse landscape’, there is evidence that theory, methodology, policy and practice are significantly underdeveloped when it comes to tackling abuse within domestic settings in later life. Unfortunately, there has been a tendency to view abuse in this context as ‘elder abuse’ and not ‘domestic abuse’, with the result that domestic abuse practice and policy responses are largely inadequate when tackling IPV in later life (Wydall, Clarke, Williams, & Zerk, 2018).

Although domestic abuse occurs across the lifespan, its occurrence in later life is a largely neglected area. Research, policy, guidance, specialist service development, professional training and consultancy appears to have focussed on victim-survivors at earlier stages of the life-course. One explanation why domestic abuse in later life has received such limited attention, is the ongoing conceptual ambiguity between domestic abuse and elder abuse, which has contributed to practitioners under-recording incidences of domestic abuse involving older people. Indeed, as noted by the Welsh Government, ‘confusion between domestic abuse in later life and “elder abuse” . . . can result in victims of abuse falling between systems which are designed to offer them protection’ (Welsh Government, 2016, p. 11). There are definitional constraints when framing domestic abuse as elder abuse, as there is no universally accepted definition of elder abuse and definitions are in a ‘constant state of flux’ (Phelan, 2013, p. 7). The World Health Organization (2008, p. 15), adopting a definition originally formulated by Action on Elder Abuse (UK), defines elder abuse as ‘a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress.
to an older person’. Notwithstanding the definitional confusion, there is a consensus regarding the multi-dimensional nature of abuse, which includes the following types: financial/material, physical, psychological/emotional, sexual, neglect (intentional or unintentional) and discriminatory abuse (Penhale, 2008). Although the general term ‘elder abuse’ helps to identify the type and nature of certain forms of abuse, the definition is too broad and all-encompassing to give clarity to fully inform policy and service development in cases of intimate partner violence.

Ironically, while disciplines such as gerontology, psychology, and health have helped to draw attention to systemic age discrimination (Biggs & Powell, 2001), an over-emphasis on ‘difference’, combined with an ageist, welfare-led, medical gaze, has influenced the type of agency response to abuse in later life, leading to age discrimination (Townsend, 1981; Clarke, Wydall, Williams, & Boaler, 2012; Wydall et al., 2018). What is evident when reviewing the research literature, is that using the term ‘elder abuse’ to describe domestic abuse in later life is disadvantageous, by default it heuristically separates older people from those at other stages in the life-course.

Rather than adopting a wider socio-ecological perspective that recognises extrinsic vulnerabilities, factors external to the individual, and how they impact on individual decision-making and help-seeking, many of the disciplines and sub fields that use elder abuse terminology tend to lean towards a response that individualises ‘the problem’ of abuse. This is clearly acknowledged by Dow and Joosten (2012, p. 853) when they assert that:

> Defining elder abuse as the occurrence of specific acts has encouraged better regulation and, in many cases, more direct support, but it risks limiting responses to being only interventions at an individual or family level. . . . the focus is mainly on carer stress or family dysfunction and thereby fails to address the systemic context in which abuse is allowed to occur. This . . . encourages an acceptance of the victim-perpetrator dichotomy, and does not take into account the complexity of the relationships between two adults, or the societal pressures and assumptions that affect individuals.

Simply individualising the nature of abuse by focussing largely on age-related intrinsic vulnerabilities, such as physical frailty and mental vulnerability, is inherently victim-blaming.

Elder abuse is a gender-neutral term that fails to sufficiently acknowledge the gendered dynamics of power and control, where women are more likely to be victims and men perpetrators (Penhale, 2003). Consequently, there is a need to make a case for rejecting the term elder abuse in the context of IPV, not only because there is a lack of conceptual clarity about how elder abuse is defined, measured and understood (Hightower, 2002) but also because of gender neutral and victim blaming assumptions (Whittaker, 1995).

**Domestic abuse in later life: the research deficit**

It is difficult to determine the true prevalence of domestic abuse in later life, when older people’s experiences are rarely captured, or only partly captured by researchers (Harbison, 2008; De Donder et al., 2016). This is particularly apparent when research methodologies designed to measure prevalence, discount domestic abuse in people over the age of 59 years. Indeed, it is only since 2017 that the largest self-report victimisation survey in Europe, the Crime Survey for England and Wales conducted by the Office of National Statistics, increased the upper age limit for recording domestic abuse from 59 to 74 years. The ageist rationale behind neglecting to capture victimisation of those aged 59 years and over was that older people would experience technical difficulties completing a computer-assisted personal interviewing (CAPI) process.
Prevalence studies of older people’s experiences of domestic abuse often do not encompass the more marginalised groups of victim-survivors (De Donder et al., 2016; Pathak, Dhairyawan, & Tariq, 2019). Thus quantitative and qualitative research data about the impact of domestic abuse (Stöckl & Penhale, 2015), help-seeking activity (Beaulaurier, Seff, & Newman, 2008), engagement with criminal justice (Clarke, Williams, & Wydall, 2016) and adult protection services and effective recovery (Brandl, Herbert, Rozwadowski, & Spangler, 2003), often only presents a partial picture. Studies involving older people invariably tend to focus on white, heterosexual women under 74 years of age, who have experienced long-term intimate partner abuse. Consequently, late onset intimate partner relationships, older male victim-survivors (Pritchard, 2007; Wydall, Freeman, & Zerk, 2020), older LGBTQ+ survivors of domestic abuse (Subhrajit; 2014; Wydall et al., 2020) and victims of intimate partner sexual violence (Bows, 2018) are under-researched, and as a result largely overlooked in policy and practice spheres.

The scant data that exists highlights that domestic abuse in later life is an under-recognised phenomenon that has considerable impact on the lives of older people (McGarry & Simpson, 2011; McGarry & Ali, 2019). However, as there is significant under-reporting and under-recording of domestic abuse, the extent of the problem remains largely unknown (McGarry & Simpson, 2011; Wydall & Zerk, 2017). A lack of knowledge about the nature of intimate partner violence particularly within certain groups of older men and women continues to restrict the development of a coherent theory, effective legislation and service provision.

In England and Wales, a non-statutory cross-government definition is in place, which defines domestic abuse as,

Any incident of pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender of sexuality. The abuse can encompass, but it not limited to psychological, physical, sexual, financial and emotional abuse.

(Home Office, 2016, p. 1)

Coercive and controlling behaviour, as a pattern of abuse used to regulate the everyday activities of victim-survivors and isolate them from social support systems is a significant feature of perpetrator behaviour (Dutton & Goodman, 2005). The inclusion of coercive and controlling behaviours in policy has been largely welcomed by academics, activists, policy-makers and service providers internationally (Candela, 2016; Stark & Hester, 2019). However, as Lagdon, Armour and Stringer (2014) note, the Home Office definition is not without its shortcomings. For example, the definition has been criticised for being ‘gender-blind’, as women are more likely to be victims of domestic abuse and men are more likely to be perpetrators (Kelly & Westmarland, 2016). The definition does, however, include abusers who are not intimate partners and this serves to widen the lens to encompass other family members; this is particularly relevant when considering cases involving older people. Whilst adult family violence is not the focus of this chapter, it is important to note that older people are as likely to be abused by other family members as they are by current intimate partners (Safelives, 2016; Wydall & Zerk, 2017).

How we define abuse will undoubtedly determine how we respond to it: definitions have consequences and will influence the nature and content of intervention programmes and prevention strategies. A victim-survivor can experience multiple types of abuse at any one time or over the life-course. Furthermore, there are significant and meaningful differences across the types of abuse, particularly in relation to the nature of victim–perpetrator dynamics. As noted by Dixon et al. (2010, p. 418) ‘definitions will need to be provisional, flexible and pragmatic’. They also need to reflect the perceptions of older people themselves. As qualitative research suggests,
older people’s understanding of what constitutes abuse or mistreatment may differ from that of policy-makers, practitioners and researchers (Erlingsson, Carlson, & Saveman, 2006; Mowlam, Tennant, Dixon, & McCreadie, 2007).

To develop a greater understanding of older victim-survivors’ experiences of abuse, and how age, gender, disability and victimhood influence their decision-making and help-seeking behaviour, the author, along with colleagues John Williams and Alan Clarke, secured funding through the National Communities Fund in 2015 to launch the Dewis Choice Initiative in 2015. ‘Dewis’ is Welsh for ‘choice’. The name was adopted to emphasise the relevance of facilitating autonomy and informed choice for older people experiencing harm and abuse by intimate partners and other family members. The next section will draw on Dewis Choice as a case study to provide insights into older victim-survivors’ perceptions of their help-seeking experiences.

**Dewis Choice (2015–20)**

Dewis Choice was a co-produced initiative comprising both service and research elements, aimed at promoting a ‘sense of justice’ and empowerment in later life. It was established in two locations in Wales: one rural and one urban (see Wydall, Clarke, Williams, & Zerk, 2019). The initiative was designed over a five-month period and involved in-depth and ongoing consultation with older people to ensure a holistic client-led, rights-based response, which integrated both justice and wellbeing provision. For five years, the service provided crisis intervention, intensive support and wellbeing strategies to help client recovery. The initiative operated within a multi-agency, adult safeguarding infrastructure to ensure clients received appropriate protection and support for a wide range of needs. Referrals to Dewis Choice were made by the police, local authorities, and health and third sector practitioners. The referral process is illustrated in Figure 14.1.

The research component of the initiative featured a longitudinal study to capture the lived experiences of older victim-survivors of domestic abuse. A key objective was to explore how prioritising informed choice influenced decision-making for people aged 60 years and over. To ensure all participants, including those living with dementia, had the opportunity to share their experiences, Health Research Authority Approval was granted through the NHS Research Ethics Committee. Of a sample of 89 older victim-survivors who engaged with the service, 46 (52%) were experiencing IPV, whereas the remainder experienced abuse by other family members. Sixty-seven older survivors talked about their experiences in a series of narrative interviews conducted before, during and after their engagement with Dewis Choice. All 46 survivors of IPV agreed to participate in the qualitative element of the research. Participants in this sub-group engaged in three or more narrative interviews over a three-year period. Participants chose the location of the interview, reviewed any previous transcripts and directed the content of the discussion. Counselling support was offered after each interview, with a follow-up meeting with the Wellbeing Practitioner, within five days after the research interview. Data were fully anonymised, encrypted and coded. Following Charmaz (2006), constructivist grounded theory was employed in the analysis of the data. This method was adopted as it accepts that knowledge is co-constructed, subjective and relativist. In comparison to other forms of analysis, Charmaz’s approach offers a more reflexive and collaborative process between the researcher and those researched. A prospective longitudinal design was chosen to gain rich insights into the dynamic contextual factors influencing help-seeking.

The development of the initiative was informed by research that drew attention to the systematic invisibility of older victim-survivors within justice-seeking domains (Wydall & Zerk,
The research suggested that people aged 60 years and over experienced ‘welfarisation’, when in comparison to their younger counterparts, practitioners diverted them away from domestic abuse resources and access to criminal and civil justice responses (Clarke et al., 2012; Clarke et al., 2016). Although it has been widely accepted that the majority of victims of domestic abuse may not want to criminalise perpetrators (Kelly, 1999; Mirrlees-Black, 1999), older victim-survivors should not be denied the opportunity to sense justice and pursue civil and/or criminal justice options. Failing to address the issue of criminality denies citizens their ordinary civil or human rights (Fitzgerald, 2006). This begs the question as to whether older adults experiencing a crime are denied access to justice as a consequence of pervasive ageist assumptions, paternalism and a particular social construction of older age.

For example, a research study that highlighted the invisibility of older adults’ involvement in decision-making was the evaluation of the ‘Access to Justice’ study in Wales (Clarke et al., 2016; Williams, Wydall, & Clarke, 2013), which involved the analysis of 131 cases of domestic abuse of people aged 60 years and over. In two-thirds of the sample, there was no evidence that older people were asked what their preferences were, nor was there any indication that civil or criminal options had been discussed with them. In addition, older people were ‘welfareised’, that is, diverted away from domestic abuse resources, which included specialist key workers, IPV risk assessment, access to legal protection, and civil and criminal justice sanctions. Interviews with practitioners, as to why older people’s views and justice options were not explored, revealed that practitioners felt the process of justice-seeking would impact negatively on the health and wellbeing of older adults. As Holder and Daly (2017, p. 788) note, ‘there has been a tendency...
by researchers, policy-makers and activists to assume the aspirations for justice of victims of domestic violence’; the process of decision-making ‘on behalf of others’ particularly resonates with the research findings that informed the development of Dewis Choice. A core ethos of the initiative was to explore all options throughout the help-seeking process and ensure help-giving was client-led and non-directive.

The next section provides an insight into the individual impact of IPV. The section will also examine how factors external to the individual influenced not only the experience of help-seeking but also the outcomes for the victim-survivors supported by Dewis Choice.

The lived experiences of older victim-survivors of IPV

Of the 46 older survivors experiencing IPV, 34 identified as female and 12 as male. Forty-three percent of this sample reported having a disability. All 46 participants were in heterosexual relationships, with two-thirds having lived with long-term abuse over more than two decades, and one-third experiencing abuse over a period of less than ten years. The demographic characteristics of this sample are presented in Table 14.1.

During their initial discussions with the researchers, over 85% of the clients experiencing IPV stated that their physical and mental health was poor. For the proportion of the sample that had experienced long-term IPV, many older victim-survivors said they had suffered abuse and coercive and controlling behaviours over many years and spent long periods ‘reframing’ their experiences as a form of coping.

I think I’ve walked on egg-shells for most of my married life, so the adrenaline is constantly pumping. I know I look a lot older than I am, I certainly feel old, older than my years. . . . The stress, the fear, it’s all been too much. I just couldn’t cope anymore and I know now it has taken its toll on me.

(Client, female, 69 years old)

Table 14.1 Demographic breakdown of clients who experienced IPV

<table>
<thead>
<tr>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>34</td>
<td>46</td>
</tr>
<tr>
<td>Long-term abuse</td>
<td>8</td>
<td>22</td>
</tr>
<tr>
<td>White British</td>
<td>10</td>
<td>30</td>
</tr>
<tr>
<td>White Welsh</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Black African</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Disability</td>
<td>5</td>
<td>15</td>
</tr>
<tr>
<td>Coercive control</td>
<td>12</td>
<td>34</td>
</tr>
<tr>
<td>Sexual abuse+</td>
<td>0</td>
<td>20</td>
</tr>
<tr>
<td>Insomnia</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Eating disorder</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>CJS engagement</td>
<td>1</td>
<td>21</td>
</tr>
<tr>
<td>Civil justice</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>% who left abuser</td>
<td>17 (8)</td>
<td>70 (32)</td>
</tr>
</tbody>
</table>

Intimate Partner Violence (Individuals aged between 60–91 years on referral)

* All seven clients also engaged with the CJS
+ Disclosed sexual abuse
Research shows that older victim-survivors of IPV are more likely to experience poorer physical and mental health outcomes than those in mature adulthood who have not experienced IPV (McGarry, 2011; Stockl & Penhale, 2015). A national longitudinal study in Australia (Loxton, Dolja-Gore, Anderson, & Townsend, 2017) examined the impact of IPV on women’s physical and mental health for three birth cohorts (1973–78, 1946–51 and 1921–26). Across all three generations, women who had experienced IPV reported to be in a worse state of physical and mental health for their age than their non-abused counterparts.

Disclosures of long-term sexual abuse and the resultant chronic urinary and gynaecological and gastro-intestinal problems took place after many months of engagement with the Choice Support Worker. Other studies have reported similar effects of long-term sexual abuse (Morgan Disney & Associates, 2000). As with other age groups, insomnia (Abath Leal, Melo Filho, & Marques, 2010; Matud, 2005) and eating disorders (Bundock et al., 2013) were present. For those engaging with Dewis, a third of female victim-survivors of long term IPV experienced both conditions.

Some interesting patterns emerged from the longitudinal data that challenged assumptions about domestic abuse in later life. For example, previous research findings suggest that emotional abuse is more frequently reported by older adults, whereas physical abuse is less common (Band-Witterstein & Eisikovits, 2009; Roberto, 2016; Stockl & Penhale, 2015); however the longitudinal research undertaken at Dewis Choice did not show a reduction in physical abuse. In the series of narrative interviews, participants all stated that as a consequence of retirement and an increase in time spent together, the levels of physical abuse had not changed. Furthermore physical abuse would intensify, as would other forms of abuse if the perpetrator was ill, about to be admitted to hospital for surgery or had been diagnosed with a terminal illness.

Establishing a rapport and building trust with researchers throughout the longitudinal study may have facilitated a more private and intimate view of the nature and forms of abuse, than with a cross-sectional research design. Furthermore, consent had been given to access the case files, and these data helped to confirm the presence of physical abuse and when there was escalation in this form of abuse, which occurred especially when the perpetrator sensed a real or symbolic loss of control. As with much contextual qualitative data, whilst the sample size is relatively small compared to quantitative approaches, the consistency of this theme across the narratives as to the presence of physical abuse is worthy of further investigation.

**Being given ‘the run around’**

On accessing Dewis Choice, those clients, both women and men, who had been exposed to prolonged coercive and controlling behaviour, felt that their self-confidence and self-belief had been severely undermined. Like victim-survivors in other age groups, they experienced a restricted ‘space for action’ (Kelly, Sharp-Jeffs, & Klein, 2014) whilst help-seeking. In addition to this, as described later, they also encountered constraints imposed by wider social conditions and stereotypical perceptions of ageing, that at times limited what may be termed their ‘scope for action’.

Although clients’ sense of agency fluctuated across service settings, thus influencing their capacity to act on their decisions, over time a growing sense of independence and self-belief helped to build ‘help-seeking resilience’. Dewis Choice clients felt that prior to receiving support, they were rarely in a position to execute decision-making; however their sense of agency increased when professionals from Dewis Choice empowered clients by providing accurate information on their rights and the resources available to them.

When clients were asked about the barriers to help-seeking, many said that prior to accessing the support offered by Dewis Choice, a significant barrier was the lack of information about
Intimate partner violence

where to find help and whether, as older women or men, they were eligible to receive support. They felt that because of their age they did not necessarily ‘fit’ into the perceptions of domestic abuse victimhood subscribed to by statutory bodies, specialist agencies and prevalent in the wider society. In this sense, the exclusion of older people from mainstream discourse is similar to Donovan and Hester’s (2014) observations regarding LGBTQ groups and their exclusion from the ‘public story’ of domestic abuse.

Clients who had previously contacted service providers, described in research interviews how these agencies had either failed to act or had taken inappropriate action at each stage in the help-seeking journey. A major source of frustration, particularly within criminal and civil justice domains, was poor communication, and the sense that the process of fair, procedural justice had not taken place. Age discrimination, and being made to feel that they were not behaving in a way victim-survivors were expected to behave, were commonly cited by participants as contributory factors in the breakdown in relations with some of the professionals with whom they came into contact. As one client noted:

as a victim you’re not supposed to get angry . . . sorry I’m getting angry now . . . the months I’ve waited by the phone in that chair, then they [solicitors] they don’t ring. Then they [the police] come around without notice, demanding, then they [the CPS] can’t even get your name right on the form . . . you are taken from pillar to post, and then dropped like a stone, because they [the police] didn’t get their result [emphasis added]. I was completely given the run-around, then they [the police] get arsey with me, as if I should be grateful . . . for what? because I’m doing all the work for them, the tax payer should pay me! It’s arghhhh, . . . you try . . . until you feel like you lost everything . . . it’s [the experience of seeking justice] really opened my eyes . . . there’s just no . . . dignity.

(Client, female, 61 years old)

Of the 22 clients who chose to pursue either a criminal or civil justice option, only two, both of whom were involved in civil cases, reported a satisfactory experience throughout each stage of the process. For others, there was evidence of victim-blaming responses. For example, if victim-survivors were perceived as being ‘non-compliant’, and challenged misinformation and/or communication processes, some professionals withdrew their support. While for some participants this withdrawal of support was only temporary, for others it was permanent: in both instances, this resulted in victim-survivors feeling a sense of helplessness and isolation if an alternative option was not available. For the seven clients who were involved in criminal or civil justice proceedings for eight months or longer, any expectation that they would be treated well diminished over time.

Among the 46 clients, there was a general awareness that the agencies they encountered in the help-seeking process had their own organisational objectives. In describing their individual experiences of interacting with representatives of these agencies, clients felt they were more likely to receive the help requested if they assisted agencies in fulfilling their organisational goals. Both female and male clients likened the process to brokering a deal. While this was particularly the case when statutory agencies were involved, the majority of clients felt all services treated them differently, in a negative sense, than younger victim-survivors at some point in the help-seeking process. As one client commented:

I am not a priority. I know that I don’t fit the type of work they do (domestic abuse service). I know what I ask for is different to what younger women with kiddies ask
for and I know there have been days when I’ve rang the office terrified, they promise to ring right back. . . . I know she (the Independent Domestic Violence Advisor) is there because they told me she was, she was, and the call hasn’t come. I know I’m not on her list . . . that frightens me.

(Client, female 69 years old, living with a disability)

The sudden absence of professional support in the aftermath of a negative court process commonly led to re-traumatisation, depression and in rare cases suicide ideation. Some clients felt harmed by the experience because the unequal power differential was not dissimilar to the actions of perpetrators. Even in cases where court outcomes were more positive, clients felt exposed and resented having to repeatedly justify their decision-making. Participants were clear and unanimous about what would improve the experience. Central to these suggestions were fair and dignified treatment, consistent communication, debunking legal jargon and the appropriate management of expectations.

Providing older people with the time and space to act on decisions was not only influenced by intersecting prejudices about age, gender and also disability, but also about how little was known by practitioners about contextual factors influencing help-seeking. Common gaps in help-providers’ knowledge were the impact of coercive control, the co-existence of dementia and domestic abuse, socio-cultural factors and an understanding of older people’s rights, benefits and pensions.

**Intersections that impact on help-seeking behaviours in later life**

Using the concept of triple jeopardy, Penhale (2016) draws attention to older women’s feelings of difference and marginalisation on account of intersections of age, abuse and gender. In the Dewis Choice study, the women’s narratives provided examples of similar marginalisation; being ‘othered’, feeling ‘different’, was an ever-present dynamic experience, which fluctuated over time and within different organisational settings. Female participants saw ageism and ageist stereotypes as significant discriminatory features when they disclosed intimate partner abuse, engaged with statutory and third sector agencies, and during recovery. Whilst sexism was present and mentioned by all research participants at some point, negative references to gender were perceived by the women in the sample to be less frequently overt and far less explicit than references to age. For the 12 older men, being male and being an older male compounded their feelings of isolation and the experience of discrimination. As one male victim-survivor commented:

Domestic abuse services, the police, everyone so far treats me with suspicion. I am made to feel like I’m odd, like I’m not ‘a man’ because somehow I can’t cope. I’m older now and I don’t have the strength to cope . . . so I think being a man and being old . . . it has made it really hard for me to find someone to talk to . . . who treats me like a human being.

(Client, male, 76 years old)

Irrespective of gender, participants stated that practitioners across criminal, civil and support services frequently commented on older victim-survivors’ behaviour if it did not conform to ageist stereotypical norms and social expectations about intimate partner relationships.

My age seems to be an issue, not for me but for other people . . . the fact I wanted a divorce in my eighties didn’t go down at all well with her [the solicitor] and I’m the
one paying! ‘What do you want a divorce for . . . at your age’ she said. ‘Well’ I thought, ‘I’m not over the hill yet!’

(Client, female, 81 years old)

There was a general feeling among interviewees that practitioners assumed that an older person, because of their age and stage in the life-course, would not want to consider leaving a perpetrator or seeking a divorce. Consequently, this was rarely, if ever, raised as a possible option with older victim-survivors.

As regards gender, interestingly, one woman attributed the lack of reference to her gender as a sign that her identity as a woman disappeared as she aged because she was no longer perceived as sexually attractive.

You disappear as a woman when you age, your ageing takes over. You lose part of yourself. So I may be ‘just silly old woman’, but I’m made to feel ‘less than’ they [the police] are, by being ‘silly’ and ‘old’ and also the ‘woman’ in me is somehow used differently now. . . . I dunno . . . perhaps I am not seen as a sexual women because I’m well past the menopause. It is really patronising.

(Client, female, 83 years old)

For both women and men, the degrees of intersectionality limited the sense of leverage they felt they had to ask for more help. This was particularly the case for men, given the gendered nature of much service provision that is geared to dealing with female victim-survivors who form the majority of cases. One of the main barriers reported by male clients was that many professionals they encountered were seen to be either unwilling or unable to ‘do more’.

In some instances, the lack of awareness agencies and practitioners had about needs, rights and entitlements on account of age, gender, sexuality, victimhood and disability, led to clients feeling unvalued and worthless. Chrisler, Barney and Palatino (2016) have reported similar age-related issues in relation to help-seeking in healthcare domains.

The co-existence of domestic abuse and dementia

Where older victim-survivors had a disability, they felt that any reference to this was avoided by the professionals they encountered in their help-seeking journeys. Many interviewees felt their disability was ‘the elephant in the room’, alongside other aspects of their identity, which professionals were unfamiliar with discussing. One client who was diagnosed with dementia whilst attempting to leave her coercive and controlling partner of ten years, discussed how isolated she felt prior to referral to her Dewis Choice. The diagnosis also led to an escalation in a range of controlling behaviours by the perpetrator:

He [the perpetrator] couldn’t stand it, the attention I was getting. There’s no advice out there [for women like me]. They are lovely [domestic abuse services]. I was told they could not help me no more. I was very sad . . . the council said you [Dewis Choice] would help me and you have.

(Client, female, 71 years old, living with dementia)

Dewis Choice practitioners worked extensively with health and social care professionals to support this client over several years. It was evident that there was a considerable divide between health and third sector organisations working in the field of dementia, and third sector domestic
abuse specialists and statutory agencies with a knowledge of IPV and coercive control. A ‘rule of optimism’ appeared to apply in cases of dementia, whereby professionals assumed intimate partners were supportive care-givers. Similar misconceptions about the nature of the relationship between care-givers and care-receivers have been found in previous studies where domestic abuse has been masked by age-related factors (Straka & Montminy, 2006; Williams, Wydall, & Clarke, 2013). One health professional commented how joint working with Dewis Choice had changed how she perceived the abuse, and how this influenced her practice:

It is bringing a whole new area of work to me, coercive control, here in health we work to a family model. So in a sense I have until now just thought ‘oh bless’, he [the perpetrator] is just struggling to adapt to her diagnosis: cleaning and cooking, not men’s roles. We just talked to them both, you tend to think the whole family will muck in and be supportive. Now I take more time to talk with her [the client] alone, I see his actions very, very differently, it has really opened my eyes to the risks where there is domestic abuse.

(Health professional, 4)

Thus, for this client, the initial response of health professionals to the husband was sympathetic, as they were not aware of coercive and controlling tactics, particularly the use of gas-lighting by the husband to further confuse the client. As noted by Bergeron (2001) and Brandl and Raymond (2012), health and social work professionals may not always recognise IPV and instead frame the harm as care-giver stress.

There is evidence that a complex interplay of intersections, such as disability, gender and age, can mask IPV and neutralise agency responses, thus producing an inequality of opportunity for older victim-survivors to engage meaningfully with services (Mattsson, 2014). Discriminatory responses led to clients lacking a voice and having limited choices, both of which had a profound negative effect not only on their sense of wellbeing but also on their own perceptions of their value as equal citizens in society.

The invisibility of older victim-survivors

Many clients claimed that help-seeking was hampered by the fact that specialist domestic abuse services did not effectively market themselves to meet the needs of people aged 60 years and over. As one interviewee commented:

I have had nowhere to go until now [Dewis Choice]. Services say they support you, but their website, photos, don’t show people like me. I’m now in my eighties, and even when I thought to knock on their door, I hesitated, many, many times. . . . I thought this [the domestic abuse service] is for younger people with families and I carried on walking. Years on, still so few services. . . . Older people don’t matter, they are invisible, I’m invisible as a victim. It is only now I can get the help, now I know what I’m entitled to, I can leave, I feel I’ve wasted years because I didn’t know who would help me as an older women. . . . I often wonder how many there are out there like me, older people, not knowing where to go for help.

(Client, female, 83 years old)

It was common for older clients to state there were very few other services available to them in Wales; this was not only the case for older women, but also true for older men, older
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LGBTQ victim-survivors and for those living with dementia or recovering from cancer treatment. Whilst domestic abuse providers are becoming more aware of the need to support older victim-survivors, efforts to resource and market their services vary considerably (McGarry, Simpson, & Hinsliff-Smith, 2014).

Starting over

While a number of studies show that older victim-survivors tend to choose to stay in an intimate partner relationship (Safelives, 2016), the majority of clients (87%) in the Dewis Choice sample chose to leave their abusive partners. This may be attributed to a number of reasons. First, Dewis Choice was a bespoke initiative, co-produced by older people, with a goal to be client-led and age-sensitive. Consequently, it was able to provide long-term, individually tailored intensive support, which would be unsustainable for other service providers. Clients, in the evaluation of the programme rated this aspect of the initiative very positively. Second, effective inter-agency working may have helped older victim-survivors to make more fully informed choices as services worked well to provide a co-ordinated community response. Collectively, these enabling factors may have had an influence on decision-making by clients and provide some explanation as to why a high proportion of clients chose to leave their abusive partner.

When viewing help-seeking from an ecological perspective, it would appear that extrinsic vulnerabilities inherent in service provision, such as ‘welfarisation’, an inability to support clients with additional needs, and discriminatory practices played a more significant role in inhibiting help-seeking than individual factors. However, adopting a non-judgemental, victim-led ethos and providing clients with the necessary time and space to explore a range of options probably helped to address these barriers to some extent. As noted earlier, the resources available provided practitioners with the ability to move beyond crisis intervention and look in more depth and detail at recovery processes.

Discussion and conclusion

Interestingly, from a longitudinal research perspective, researchers noted how that by engaging in a series of narrative interviews, over time victim-survivors began to attribute greater responsibility for the IPV to the wrong-doer. It became increasingly noticeable how a moral dimension emerged and developed as the narratives of victimisation unfolded in the series of interviews. The narrative technique also allowed the individual to uncover and explore in depth the impact of experiencing wrong-doing on their sense of identity and wellbeing. The process of collaboration and autonomy in the qualitative research appeared to create an empowering sense of authorship when re-constructing this period of victimisation in participant’s life story. Many individual survivors reported that they felt a therapeutic benefit from sharing their lived experience with the researchers. As non-judgemental receivers of the narratives, researchers felt they provided a safe space for participants to explore temporally the experience of victimisation and its aftermath. The extent to which the use of collaborative research methodologies that involve a series of narrative interviews can also contribute towards wellbeing is well-documented (Laslett & Rapoport, 1975; Olson, 2016). For participants, the process of sharing their experience and making themselves more visible as victim-survivors of domestic abuse was very important. As one client stated: ‘If this [research] helps just one person, just one, I know I will have made a difference, and that really matters to me’ (Client, female, 72 years old).

In conclusion, research about older people’s ‘lived experiences’ of domestic abuse still only exists in the margins and this has led to limited theory and policy development. This, in turn,
has restricted opportunities to resource responses that provide ‘expanded space for action’ to meet the needs, rights and entitlements of a diverse group of older victim-survivors. The findings from Dewis Choice highlight how intersections of age, disability and gender act as a barrier to help-giving. A lack of knowledge about older victim-survivors’ needs has a significant impact on the experience of help-seeking and this can inhibit older victim-survivors’ ability to make informed choices and limit their scope for action.

Despite an increase in public interest about age and ageing, the discourse around domestic abuse continues to ‘other’ older women and men by reframing and de-gendering the experience under individualised victim-blaming discourses. Systemic ageism has resulted in ‘welfarisation’ and discriminatory practices leading to the underdevelopment of policy and practice aimed at supporting older victim-survivors especially within domestic abuse sectors. Whilst there are some signs that services are becoming more age-sensitive in cases of older IPV, there is still a significant gaps in the ‘public story’ of domestic abuse. The absence of resources committed to tackling IPV in later life by policy-makers, practitioners and researchers serves to legitimise domestic violence and abuse against older women and men in society. A transformative rights-based approach is required to raise the awareness about the nature and extent of IPV in later life. Domestic abuse occurs across the life-course, and societal responses to help-seeking should not diminish with age.

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Critical findings

- Including older people in service design, implementation and governance of domestic abuse services will assist in making the response to tackling domestic abuse more age-sensitive.
- Paternalism, acting on behalf of older people, rather than allowing them the opportunity to make informed choices, is ageist.
- Stereotypical views about ageing, lifestyle choices and sexuality may not only mask the presence of intimate partner violence, it may also lead to discriminatory policy, practice and research.
- Accessing justice is a basic human right; current responses to older victim-survivors aged 60 years are discriminatory when compared against the service responses to victim-survivors aged 59 and under.
- Where care-giving is a feature, coercive and controlling behaviours by perpetrators can lead to further isolation and an increased risk of harm. Practitioners should avoid a ‘rule of optimism’ especially where dementia has been diagnosed.

Implications for policy, practice and research

Policy implications

- This research, and others, has highlighted how domestic abuse policy and feminist discourse on this subject needs to be more inclusive of older victim-survivors of intimate partner violence and adult family violence.
• Policy guidance needs to explore in more depth the intersection of age in relation to males, LGBTQ groups and those living with a disability.
• Safeguarding policy and domestic abuse policy is not sufficiently integrated to address the needs, rights and entitlements of older victim-survivors of domestic abuse; this results in ‘welfarisation’ whereby older people are diverted from domestic abuse practice including domestic abuse risk assessment, specialist resources and access to justice options. Diversion away from specialist support increases the risk of serious harm and denies older people their basic human rights.

**Practice implications**

• Imagery used by services providing specialist domestic abuse support needs to better reflect the diversity of three generations of older people, so that all victim-survivors know the service is inclusive of their needs. Language also needs to be age-sensitive, and include reference to LGBTQ victim-survivors and older men.
• Training is required to incorporate the needs of all older individuals, particularly those who experience intersections of disability and age; training on legal guidance that protects older victim-survivors’ rights and entitlements is a significant gap, especially where there is a co-existence of domestic abuse and dementia.
• As disclosures of abuse, particularly sexual violence and abuse may take longer, further consideration needs to be given to training dedicated workers to support older victim-survivors, and providing longer-term support where possible.

**Research implications**

• Prospective longitudinal qualitative research has helped to capture the dynamic and complex circumstances in which older people experience abuse, and highlight the numerous barriers they face when help-seeking. Further qualitative research is required to capture older LGBTQ groups, and older men in particular.
• Quantitative and qualitative studies should include all age ranges to capture the experience of domestic abuse along the life-course. This requires factoring in time to reach more victim-survivors who may exist on the margins.

**Notes**

1 The majority of male and female research participants who shared their lived experiences with the researchers preferred to use the term ‘victim-survivor’. (See also Donovan & Hester, 2010.) However, the use of terminology was complex and transitory; for example, most participants felt that on their first disclosure to professionals, they were not recognised as victims *per se*, and that external validation of their victim status was important. More generally, participants felt the term ‘victim-survivor’ was more positive than the term ‘victim’, as this signified movement along an often non-linear continuum from victim to survivor. Formal and informal responses after a disclosure impacted significantly on individual interpretations of terms used. For the purpose of this chapter, the term victim-survivor or client will be used interchangeably.

2 Intimate partner violence (IPV) is domestic abuse by a current or former spouse or partner in an intimate relationship against the other spouse or partner.

**References**

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