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The experiences, needs of, and support for older women survivors, and how services respond to them.

Emma Louise Finnegan

A commentary submitted in partial fulfilment of the requirements of the University of Northumbria at Newcastle for the degree of Doctor of Philosophy by published work.

Date of submission 31/01/2022

Abstract

Despite some acknowledgment that older women can be victims of violence and/or abuse, there is a dearth of empirical research in this area. There is also little known about the challenges services face in recognising and responding to older survivors. Given the negative consequences on victims and the ever-increasing aging population, there is reason to address these gaps. By incorporating older women's experiences into a field where they have largely been ignored, this study makes an original and valuable contribution to feminist criminology and victimology. Further, by detailing the experiences of professionals and highlighting the challenges they face, I contribute to past research but add originality by considering the effects of austerity and neoliberal ideology.

My research applies a qualitative approach that is contextualised in an intersectional feminist framework, informed by social constructionism epistemology. Data collection involved in-depth interviews with 13 older women who self-defined as experiencing violence and/or abuse after the age of 60, and 21 professionals from two distinct groups, namely social services, and domestic abuse and/or violence (DVA) organisations. All practitioners have experience of working with older women victims/survivors.

Through this in-depth exploration, that listened to the voices of older women, experiences of violence and/or abuse which are undocumented in previous published UK studies, are showcased. This includes coercive control within family relationships, abuse by adult children, abuse by professionals, and details of abuse in care homes**.** Further, by taking account of the views of practitioners who support older women survivors further light is shed on their ability to recognise and respond to older victims. Originality is added by exploring the effects of austerity and neoliberal ideology. Additionally, it has been inferred by some professionals that social workers refrain from referring to specialist DVA organisations. My findings not only demonstrate this, but also derive from the accounts given by social workers themselves.

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List of main abbreviations

AEA	Action on Eder Abuse
ADASS	Association of Directors of Adult Social Services
CA	Care Act 2014
CFAB	Centre for Ageing Better
CSEW	Crime Survey for England and Wales
DA	Domestic abuse
Department of Health	DoH
DV	Domestic violence
DVA	Domestic violence and/or abuse
EA	Elder abuse
HO	Home Office
IPV	Interpersonal violence
NDA	Non-domestic abuse
LA	Local Authority
WHO	World Health Organisation

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Declaration

I declare that the work contained in this thesis has not been submitted for any other award and that it is all my own work. I also confirm that this work fully acknowledges opinions, ideas and contributions from the work of others. The work was done in collaboration with Brown Consultants.

Any ethical clearance for the research presented in this commentary has been approved. Approval has been sought and granted through the Researcher's submission to Northumbria University's Ethics Online System on 01/07/2018 (submission ID: 13010).

I declare that the word count of this Thesis is 84,069

Ms E L Finnegan

Chapter 1: Introduction

1.1: Introduction

Violence and/or abuse in later life is a neglected area in policy, practice, and research, especially when compared to younger groups (Hall, 2017; Meyer et al, 2020; Wydall et al, 2019). Despite some recognition older people can be victims and the term elder abuse (EA) often defines the abuse of older people, there is a paucity of empirical research examining victimisation against them (Bows, 2019a; Bows, 2019b). Feminist research has long been at the forefront of examining violence in women's lives (Stanko, 1990). However, this largely focused on younger women. Consequently, the experiences of older women have been somewhat ignored (Bows, 2019a, 2019b). Despite calls to listen to the voices of older women survivors (Blood, 2004; Fileborn, 2017), there is a dearth of research listening to their lived experiences (Carthy and Taylor, 2018; Wydall et al, 2019). There are also a limited number of studies exploring the experiences of adult social services and domestic violence and/or abuse (DVA) organisations when supporting older victims (Bowen and Searle, 2019; Carthy and Bowman, 2019).

This introductory chapter outlines the background to this study, which listened to the voices of women, aged 60 and over who have experienced violence and/or abuse, and the experiences of two groups of professionals who have supported older women victims. First, it sets out the justification and research questions that guided the study. Next, the contextual background is given whereby attention is given to the ageing population and their risk of victimisation, and the systematic invisibility of older victims. This chapter then details the debates surrounding definitions and provides the terminology used in this thesis. Following this, the theoretical and philosophical framework which underpins this research is presented. Lastly, this chapter outlines the structure of this thesis. Before proceeding, it is important to note that there is no single definition for abuse against older people, and various studies use a variety of terms, including domestic violence (DV) (Council on the Ageing et al, 2000), domestic abuse (DA) (McGarry and Simmpson, 2010, 2011), and intimate partner violence (IPV) (Stockl et al, 2012) when exploring victimisation against older women. Consequently, different terms will be seen below, and throughout this thesis. I will return to definitions later.

1.2: Justification and research questions

Violence and/or abuse of older people has largely been overlooked by researchers. Instead, the focus has been on victimisation against younger women, particularly when it is intimate in nature (Meyer et al, 2020). Bows (2018, 2019a, 2019b) recently highlighted the absence of research in this area, and Wydall and colleagues (2019) acknowledge that:

> *'The lived experiences, the voices, the wishes, needs and rights of older people appear to have been largely overlooked in much policy, practice and research.'* (p.29)

There is also Government recognition that older people's voices are ignored:

> *'The voice of older people is rarely heard by those who have a responsibility for commissioning, regulating and inspecting services.* (House of Commons Health Committee, 2004, p.5)

Hall (2014) argues that if the voices of older survivors *'do not make a more regular appearance in (..) research'* they will be further marginalised (pg.118). Furthermore, Blood (2004), Carthy and Taylor (2018), and Fileborn (2016) highlight the need to listen to the first-hand experiences of older women victims. However, there are few published studies in the UK, in the last 20 years, that have listened to the voices of older victims. Prior to this, research mainly considered the views of doctors (Bennett, 1990a, 1990b, 1990c, 1990d, 1990e; Ogg and Bennett, 1992a, 1992b), or doctors and social services (McCredie, 1991). When studies have listened to the voices of survivors, they are mostly limited to DV or DA that occur between heterosexual partners living in the community (Lazenbatt et al, 2013, 2014; Mc Garry 2010, 2011; Scott et al, 2004). When wider perpetrators (Mowlam et al, 2007; Naughton et al, 2010), and settings (Homer and Gilleard, 1990; Pritchard, 2000a) are included, there is no analysis of the possible differences in survivors' experiences. After conducting a systematic review of qualitative literature, Meyer and colleagues (2020) recognised the need for further studies to include victimisation beyond intimate partner violence (IPV) by incorporating wider perpetrators and settings. Further, despite calls for researchers to consider adopting an intersectional lens when exploring EA (Bows, 2018), there are no published studies in the UK taking this approach (Bows, 2019a).

My inquiry seeks to ameliorate this by including a range of perpetrators, different relationships between victims and perpetrators, and abuse that occurs in institutional settings. Also, by employing an intersectional feminist framework, this research moves beyond past studies.

There is a limited number of studies exploring the way DVA organisations and adult social services respond to violence and/or abuse against older people, and what challenges they face. However, research in this area is not wholly absent. As set out in Chapter 2, Carthy and Bowman (2019) and Bowen and Searle, 2019) explore these issues. My study extends their inquiry by examining the types of intervention DVA organisations and adult social services initiate for older victims. While there is some insight into interventions social services initiate for older survivors, no light is shed on how their approach compares to DVA organisations, or possible differences between DVA survivors and victims of abuse that is not domestic in nature (NDA) (Yechezkel and Ayalon, 2013). Moreover, there are no known studies which evaluate how power dynamics, which are shaped by inequalities, inform services responses. Such research is required to increase understanding of how age and the interplay of the intersections of gender, disability, and ethnicity impact on services engagement (Wydall et al, 2017).

Recognition of gaps in knowledge led to the formulation of two overarching research questions and seven aims that seek to answer these questions, as follows:

1) What is the nature and impact of violence and/or abuse against women aged 60 and over?

I: What types of violence and/or abuse are experienced?

II: What factors impact on experiences of victimisation, and to what extent do they act as barriers to leaving and/or seeking support?

III: What is the impact of violence and/or abuse?

IV: What services and/or support networks do older survivors access and what are their experiences of this?

2) What can the experiences of professionals from social services and DVA organisations tell us about violence and/or abuse against older women?

V: How do DVA organisations and social services recognise and respond to victimisation against older women?

VI: What challenges do services face when working with older survivors?

VII: Do support needs of older victims differ to younger survivors?

1.3: Contextual background

This section provides the contextual background for this study. It highlights the ageing population and how older women are at increased risk of victimisation when compared to their male counterparts. Following this, the systematic invisibility of older victims is set out by drawing attention to how official data excludes many victims.

1.3.1: The aging population and risk of violence and/or abuse

Abuse is unacceptable at any age, but we are living in an ageing population. The United Nations (UN) have estimated that the Global population of over 60s will double to approximately 1.2 billion by 2025 (UN, n.d). Within the UK there are nearly 12 million people aged 65 and over and this number is projected to increase by 8.6 million by 2068 (Office for National Statistics (ONS), 2018a). With greater longevity and a growing older population, incidents of violence and/or abuse will continue to grow at a rapid rate, (Aday, 2017). Choi (2017) argues that due to multiple disadvantages which are grounded in traditional gender roles and economic disparities, older women are more vulnerable to victimisation than their male counterparts. UK research supports this view as it indicates older women are more at risk than older men (Bows and Westmarland, 2017; O'Keeffe et al, 2007; Naughton et al, 2010).

One disadvantage that is ground in traditional gender roles is poverty. Older women are often poor, with recent UK figures showing that 23 percent of single female pensioners live in poverty, compared to 18 per cent for single male pensioners (Women's Budget Group (WBG), 2018). This is a result of how family circumstances impact on women's employment and lives more severely than men. Many women who work undertake most of the care for children and other relatives and are more likely to

work part- time (Centre for Aging Better (CFAB), 2019a). Poverty can exacerbate incidents of abuse by increasing or prolonging women's exposure to it and reducing their ability to flee (Women's Aid, 2019). When gender intersects with race and disability the situation is more acute because women from minority groups and those with disabilities face a higher risk of poverty (WBG, 2018). The link between poverty and abuse in institutions seems uncharted in the UK, but research from America indicates that being less well-off financially increases risk of victimisation in residential care settings (Hawes, 2003).

Older women are more likely to be socially isolated, badly housed, and unhealthy (CFAB, 2019b). These socio-structural factors are recognised as contributing to many aspects underpinning abuse against older people (Hall, 2014; World Health Organization (WHO) and International Network for the Prevention of Elder Abuse (INPEA), 2002). As people age, they tend to develop long term conditions and require more health and social care needs (National Health Service (NHS) England, n.d). Many health problems are more prevalent when older people are less wealthy. Older people who are less well-off financially often have one or more health issues, such as: angina, diabetes, depression, osteoarthritis, and cataracts, and are significantly more likely to be frail (CFAB, 2019b). Older women suffer more than older men from ill health, disability, and depression (Carmel, 2019), which increases older women's risk of victimisation (Fisher and Regan, 2006; Flueckiger, 2008; Luoma et al, 2011). As explored in Chapter 3, health issues can present additional barriers to disclosure which prevent older women from gaining support (SafeLives, 2016; Scott et al, 2004; Jones and Powell, 2006; Zink et al, 2003, 2005). It is however essential to note that all older people live in poverty, are frail or isolated. Snyder (2014) contends that older groups are the most diverse cohort with many variations in their outlooks, lifestyles, and health. Many are extremely active, volunteer, care for younger relatives, study at university or take short courses (Minocha et al, 2013).

Due to the ageing population and greater longevity, violence and/or abuse against older people will continue to rise (Aday, 2017), thus leading to an increase in victims who are more likely to be women. Furthermore, it is a systemic, widespread, and pervasive violation of the human rights and dignity of older people (Help Age International (HAI) 2017a; 2017b). The consequences are dramatic and long-lasting,

with older people experiencing a decline in physical and mental capacities and sometimes developing feelings of rejection and exclusion (Age Platform Europe, 2017). It can also be fatal (Bows, 2018), and recent statistics and research indicate that domestic homicide of older women is a growing pressing concern (Bows, 2018; Holt, 2017; ONS, 2020a). Despite evidence that violence and/or abuse against older groups occurs, and some awareness of the impacts, the issue of victimisation against older people remains largely hidden (Hall, 2014; Meyer et al, 2020).

1.3.2: The systematic invisibility of older victims

Official data is limited in various ways (Bows, 2019a, 2019b), which alongside an absence of research, restricts our knowledge about victimisation against older people. Instead, we rely on data that only captures victimisation against certain types of victims. Bows (2019a) expresses caution against this, by pointing out how this limited data is often used to inform and justify how resources are allocated, impacts on policy, and affects practice developments. In terms of policy, it was not until the late 1980s that the subject of abuse against older people started to be taken seriously by State officials (Penhale, 2008). It then took over a decade for the UK Government to indicate it was considered a problem, warranting attention (Department of Health (DoH), 1993). Despite this earlier recognition, the victimisation of older groups still largely remains on the periphery of key developments and discussions (Hall, 2017; Wydall et al, 2019).

The invisibility of older victims is apparent when considering official data. In some cases, older people are excluded. For instance, the aims to eliminate violence against women set by the UN in 2015, are all based on research examining 15- to 49-year-olds only (UN, 2015). Similar exclusions can be seen at a national level. Previously the Crime Survey for England and Wales (CSEW) neglected to include IPV against those aged 59 and over. Since April 2017, the cut off age was extended to 74 (Elkin, 2021). While this is an improvement, it conceals victimisation against those aged 74 and over. Further, Lynn and colleagues (2000) argue that the older generation are more likely to struggle in defining themselves as victims and decreased willingness to disclose to surveyors. The CSEW also excludes institution settings, which is problematic because victimisation is rife in these settings (Krug et al, 2002; Yon et al, 2018). All these factors impact on the reliability of CSEW. A failure to accurately identify trends of violence and/or abuse against older people, contributes to their invisibility. Moreover, evidence consistently shows that older people are not

represented in DA services (SafeLives, 2016), and research indicates older women are less likely than younger women to report DA to the police (Acierno et al, 2001). This further adds to their systemic invisibility, which in turn helps shape and crystallise the view that older people are not abused (SafeLives, 2016). This arguably impacts on the research agenda. Researchers may see no merit in examining victimisation against older people because it seems so rare.

Violence and/or abuse against older people includes incidents that occur in institutions, or are committed in the community by, for example neighbours, and care workers (Kalaga, 2004). Safeguarding data includes types of abuse not covered by the CSEW which includes victimisation in institutions (NHS Digital, 2018, 2019, 2020, 2021). However, it only provides a partial picture of abuse and neglect against older people. It is reliant on an individual or professional, such as GP, to report a safeguarding concern to their local authority (LA). This is problematic because professionals can fail to recognise it and report it (SafeLives, 2016). It is further restricted because it only covers adults who are deemed at risk of abuse and neglect due to their care and support need(s) (Care Act 2014 (CA), s42(1)) which excludes many older victims. I return to this in Chapter 2. Of key importance for my purposes, is there is no breakdown by age of the circumstances of abuse and no separation of the nature and characteristics of victimisation (Action on Elder Abuse, (AEA), 2017). Consequently, it is impossible to ascertain what types of victimisation older groups are exposed to or how characteristics, such as gender and ethnicity intersect with age and risk of abuse.

1.4: Definitions

Definitions are significant because they facilitate identifying the social problem and offer guidance to enquirers which help them make sense of the issues involved (Biggs el al, 1995). They also reflect different understandings about causation, prevention, and strategies for recognising and responding to victims (Donovan and Hester, 2010). When examining violence and/or abuse against older people, matters are complicated. This is partially because there is no single definition for victimisation against older people, and different studies use different age categories (Baker et al, 2009; Council on the Ageing et al, 2000; O'Keeffe et al, 2007; Soares et al, 2010). These two

interrelated issues are explored below. Debates surrounding the appropriateness of the 'terms' victim and survivor are also presented.

1.4.1: Defining violence and/or abuse against older people

Abuse of older adults was initially identified in the UK in the mid-1970s (Penhale, 2008). At this time, the term adopted was *'granny battering'* (Burston, 1975). Mysyuk and colleagues (2012) suggest this revealed the often ageist assumptions that lay behind older victims labelling, whereby they were viewed as weak, powerless, and vulnerable, and passive recipients of care who were a burden to their family. They further argue that despite this term being offensive, stereotypical, it was accepted and used. Initially, this was by the medical profession, but it was soon adopted by the social and health care sector (Eastman, 1982). Partly in response to increased interest and research into the phenomenon, this inappropriate early term underwent many changes (Slater and Eastman, 1999). EA is now often adopted (Biggs et al, 1995), and seems to be the most frequently employed term to define abuse and neglect of older people (De Donder et al, 2011; Yon et al, 2017). It is also adopted by the WHO (WHO, 2021).

Various academics and researchers critically acknowledge the lack of agreement concerning the parameters of the term EA because some studies exclude certain perpetrators, while others ignore certain types of abuse (Aday et al, 2017; Clarke et al, 2016; De Donder et al, 2011; O'Keeffe et al, 2007). For example, most disregard strangers (O'Keeffe et al, 2007), while others include them in their remit (Naughton et al, 2010). Certain types are sometimes ignored, with Bows (2017a) arguing that this is more acute for sexual violence. The research focus often differs, some investigators focus on sexual violence only (Bows and Westmarland, 2017), while others examine DA against older women more broadly (McGarry and Simpson, 2010, 2011). Others examine IPV (Stockl et al, 2012), and some explore Domestic Violence (DV) (Council on the Ageing et al, 2000). Moreover, different jurisdictions, policies, and researchers all adopt different terms and meanings for different types of abuse and/or violence against older people (Bows, 2017a). Thus, the way, for example, sexual violence is defined can vary across studies. Despite the difference in the terms used there seems to be an absence of explanation of how violence differs from abuse or whether they are seen as synonymous. Although there is a lack of consensus regarding the parameters of EA, it has long been recognised that the main types are: physical abuse,

sexual abuse, financial abuse, psychological and/or emotional abuse, and neglect (Penhale, 2008). Other categories can be added to this. Statutory guidance to the Care Act (CA) (2014) includes, physical, DA, sexual, psychological, financial, or material, modern slavery, discriminatory, organisational, neglect and acts of omission, and self-neglect (Department of Health and Social Care (DoH and SC, 2020).

Research has shown that definitions used by older victims do not always correspond to those used by practitioners (WHO/INPEA), 2002). Professionals conceptualise most definitions with little consideration of the perceptions of older people or the heterogeneity within older populations, or how older victims define their experiences of abuse (Walsh and Yon, 2012; WHO/INPEA, 2002). Moreover, a project in Australia that examined DV against women aged over 50, found that out of 140 participants, 40% did not perceive their experiences as DV (Council on the Ageing, 2000). This was despite respondents agreeing they had been subjected to violence within the given definition. Furthermore, older women often have a range of understandings and views of what constitutes rape and sexual assault, with many not situating their experiences within definitions given in studies (Mann et al, 2014) or ones in polices or by legislation (Hamby and Koss, 2003). Thus, while legislation, policies, and terms in research, aim to be clear, social constructions and perceptions differ significantly. Consequently, when individuals are asked to discuss their experiences in line with set definitions, it can confound findings because they do not understand their situation as fitting within the given terminology. Imposing definitions on survivors arguably hinders their ability to fully account for their experiences of victimisation. Listening to the voices of victims and professionals is key to my research. Thus, no definitions were imposed upon participants. For a discussion of this, see Chapter 4.

In this thesis I use different terms. This is because there is no single definition for violence and/or abuse against older people. However, definitions employed by the study or organisation in question will be adhered to. For instance, when studies examine DA (McGarry and Simpson, 2010, 2011), to remain faithful to the research as it was conducted, the term DA will be used. Likewise, when literature uses the term EA (for example, Kabelenga, 2018; Penhale, 2003; Yon et al, 2017), this will be used. Also, other phrases will be utilised, such as, abuse and/or violence against older people, and victimisation against older people.

Victimisation can include DVA. DVA has recently been defined in the Domestic Abuse Act (2021) as:

"Behaviour of a person (A) towards another person (B) is domestic abuse if –

> *(a) A and B are each aged 16 or over and are personally connected to each other, and*
>
> *(b) The behaviour is abusive"*

Behaviour is classed as abusive if it consists of any of the following: physical or sexual abuse, violence or threatening behaviour, controlling and coercive behaviour, economic abuse, and or psychological, emotional, or other abuse (s1.3). People are classed as being personally connected if they are, or have been married; they are, or have been in a civil partnership; they have agreed to marry each other; they have entered into a civil partner agreement; they are, or have been in an intimate personal relationship with each other; they each have, or there has been a time when they each have had, a parental relationship to the same child; they are relatives (s2.1). When abuse and/or violence does not meet this definition, because for example it has been committed in an institution, or in the community by a care worker, I adopt the term non-domestic abuse (NDA). The abbreviation DVA will be used to collectively refer to professionals in DV, DA and IPV services. As explored in the next section, there are issues with defining 'older', which causes problems when measuring violence and/or abuse sustained by older people (Bows, 2019a).

1.4.2: Defining older

Old age and ageing are fluid concepts which vary depending on the literature consulted and the discipline operated in (Snyder, 2014). Debates regarding what constitutes older are historically grounded and seem unlikely to be resolved. For instance, in Greek society Pythagrous suggested old age commenced at 60, while Plutarch considered it started at 50 (Bytheway, 1995). In the UK, Government departments often use 50 as a benchmark, while the Crown Prosecution Service (CPS) policy for prosecuting crimes against older people defines this group as 60 and over (Chivite- Matthews and Maggs, 2002; CPS, n.d). Also, within existing research, different age categories are used. For example, one study sampled people aged between 60-84 (Soares et al, 2010), whereas the starting point for another is 66 and

included people aged 85 and over (O'Keeffe et al, 2007). The lowest age used in studies appears to be 50 (Baker et al, 2009; Council on the Ageing et al, 2000).

While there are debates on what constitutes old and who is seen as older, it seems accepted that in Western society there are two principal approaches to theorising age, the biological stance, and social constructionism (Wilson, 2000). From the biological standpoint attention is focused on how physical appearances and cognitive ability alter overtime (Snyder, 2014). In contrast, social constructionism anchors their interest in how age is socially constructed and how socially defined expectations shape how individuals or groups believe people of a certain age should act and behave (Wahidin and Powell, 2007). While there is an understanding that the concept of age is socially and culturally constructed, as well as being demonstrated in biological changes, these two factors are often merged. This can lead to ageist assumptions that see socially constructed disabilities associated with ageing, such as slowing down, as natural, and inevitable (Rubinstein, 1990). As examined in Chapter 2, this is problematic as ageism impacts on how victimisation against older people is responded to, and fuels abusive situations (HAI, 2017a, 2017b; Penhale, 2003). I adopt a view that recognises that age is socially constructed, and that older people form a diverse cohort who act and experience their lives in different ways, irrespective of chronological age.

While I embrace the social constructionism approach, it is essential to set a benchmark to allow for an examination of victimisation against older people. The definition of older for the purposes of this doctoral research is aged 60 and over. There are no restrictions regarding an upper age limit. While any age chosen is arbitrary, there are justifications for using 60 as the starting point to define older. Firstly, the WHO (2018) generally use aged 60 and over to refer to the older population. Second, in a recent global-meta-analysis and systematic review of 52 studies across 28 countries, it was found that most studies adopted 60 as their starting point when examining EA (Yon et al, 2017).

Identification of the group of people relevant is necessary to have meaningful discussions about victimisation against older groups. Thus, I use the term 'older people' but the phrase 'elderly' is avoided. Biggs et al (1995) argue that the term elderly reinforces a depersonalised and inaccurate description of those later in life. However, Aitken and Griffin (1996) and Penhale and colleagues (2000) have acknowledged that both the term older people and elders can be regarded as ageist

and causing segregation. To mitigate issues, I adopt a value position that supports the view that older survivors should be accorded full legal status and rights as citizens. This position is further strengthened by situating this research within a feminist framework, which as returned to in Chapter 4, may serve to recognise and promote the human rights of older victims (Penhale, 2003). I now set out the debates regarding the appropriateness of using the term victim or survivor.

1.4.3: Victim or survivor

The term victim is generally used to describe someone who has suffered harm, directly caused by a criminal offence (Ministry of Justice (MOJ), 2015). Heavy criticism has been levelled against the term victim because it is seen as carrying victim-blaming connotations and portrays individuals as passive, helpless, and dependent (Stringer, 2014). As the feminist movement sought to empower victimised women, a preference to use the term survivor emerged (Kelly, 1998). Describing women as survivors was seen to emphasise the more active and positive image of women (London Rape Crisis, 1984). In highlighting these aspects, the efforts of abused women to protect themselves and their children, and their ability to mobilise resources to survive was made visible (Kelly, 1998). However, there remains a lack of consensus among women and men regarding the term they prefer to use, and some scholars highlight the tensions between being labelled either victim or survivor. For instance, Walklate (2017) argues that both labels fail to capture the processes of victimisation and the complex realities of women's lives. Different organisations tend to use different terms. For instance, the criminal justice system tends to utilise the term victim (Ministry of Justice, 2015), whereas community-based advocates and other similar service provisions mainly employ the term survivor (Sexual Assault Kit Initiative, n.d).

While I prefer the phrase survivor because it invokes images of power and resistance, I use both the term victim and survivor. Within the literature review, fatal violence against older people is discussed. Using the term survivor is inappropriate in this context. Additionally, using both helps avoid repetition.

1.5: Theoretical and philosophical framework

An intersectional feminist theoretical framework that is informed by social constructionism epistemology is adopted for my study. Abuse at any age can impact on both men and women, but women across all age groups are at greater risk of victimisation than men, particularly when it is intimate in nature (WHO, 2017). Consequently, the significance of gender cannot be disregarded and abuse in later life, similarly to younger groups, can be seen as a form of violence against women. Deriving mainly from feminist academics and the grassroot movement, feminist studies have been at the forefront of research examining *'everyday violence'* in women's life (Stanko, 1990). Violence against women has been conceptualised as an expression of social power which is used by men to dominate and control female partners (Rakovec-Felser, 2014). Feminist researchers prefer to use qualitative research, focusing on listening to survivors' stories (Oakley, 1981). By emphasising the voices of victims, feminist studies, alongside activism, transformed the political and legal landscape (Houston, 2014). DVA is consequently now recognised as a public matter warranting State intervention, as opposed to a private matter. Due the emphasis placed on both structural and individual levels of oppressions experienced by women across their life course, in a patriarchal society, and the insistence feminist research should challenge these injustices and transform them (Chesney-Lind, 2006; Schecter, 1982), a feminist framework is appropriate for my study.

Feminist research has been recognised as a legitimate and relevant research model (Sarantakos, 2013). However, first wave feminism was criticised for failing to consider other inequalities and social factors which can shape the experiences of victimisation (Crenshaw, 1991). Intersectionality is a feminist framework that can address this gap. It provides an approach which recognises how systems of power, such as gender, race and class interconnect and are axes for analysis (Nash, 2008). Women are not a homogenous group and their experiences of DVA are not limited to their gender alone (Crenshaw, 1991, 2003). Nevertheless, despite an awareness that intersectional theory enables an examination of how victimisation is experienced within the context of multiple dimensions of someone's identity, it has not been applied to the study of violence and/or abuse against older people (Bows, 2019a). As discussed in Chapter 4, intersectionality provides an anchor that enables researchers to acknowledge the

multiple identities and institutional structures that can disempower historically and currently marginalised groups (Crenshaw, 1991). In doing so, it facilitates the development of a more nuanced understanding of victimisation against older people that is obscured by focusing on gender alone. Furthermore, intersectionality is more than just a theoretical tool. Its insistence that we move away from single axis and binary thinking helps ensure services, including DVA organisations and social services, take account of the various needs of survivors. Polices, priorities or strategies of services often disregard the particular intersectional needs of many women (Crenshaw, 1991), including older women (SafeLives, 2016). Additionally, due to ageist assumptions which are inexorably linked to the concept of vulnerability, older victims can be subjected to paternalistic treatment and consequently disempowered (Blood, 2004; Lonbay, 2018). An intersectional feminist framework is therefore beneficial because it draws attention to how power dynamics operate and inform services responses to older victims (Crenshaw, 1991).

My study listened to the voices of abused older women and practitioners, with a view of exposing their subjective experiences. To facilitate this process a social constructionism epistemology is adopted. This approach maintains that individuals create or construct understandings from their experiences and through interaction with broader social factors (Allen, 2004). Consequently, there is no 'one reality' or one 'truth'. Instead, there are 'multiple realties' which can be accessed through a variety of analytical tools (Corbin and Holt, 2005). There is however a preference for methods that allow individuals to express their experiences, in their own words (Creswell, 2013; Allen, 2004). This is because listening to individuals' stories can provide a challenge to the oppressive domains of knowledge construction which in turn facilities change (Coale, 1994). Similarly, to intersectionality, social constructionism questions taken for granted assumptions and permits a critical exploration of how victimisation against older people is often ingrained in societal attitudes (Hall, 2014, Penhale, 2003). Although social constructionism facilitates listening to the voices of individuals with the aim of facilitating change, when research has taken account of lived experiences, investigators have not employed this epistemological approach.

Exploring victimisation against older people through intersectionality, as informed by social constructionism epistemology provides a critical perspective that questions notions such as gender, old age, and vulnerability, by reflecting on how they are social constructs (Hall, 2014). It enables us to analyse how power has clustered around certain categories and constructs, and is exercised against others (Crenshaw, 1991). In doing so, it helps reveal explicit and implicit assumptions about social categories and avoids essentialist notions that obscure the root causes of victimisation, particularly the ingrained societal attitudes towards age and older people (Hall, 2014, Penhale, 2003). It provides a challenge to dominant power structures and facilitates change (Shulamit, 1992; Allen, 2004; Westmarland, 2001). Kabelenga (2018) argues that this approach also acknowledges that those who have experiences or observed EA, are best placed to describe their experiences.

1.6: Thesis structure

This introductory chapter set out the questions guiding my research and justified these by pointing to the gaps in research. The contextual background for this study was provided by drawing attention to the ageing population and risk of victimisation, how risk acutely impacts on older women, and the systematic invisibility of older victims. This introductory chapter also introduced the theoretical and philosophical framework which I return to in Chapter 4. Key definitions relevant for my study were discussed and the criticisms concerning definitions of EA were mentioned. A discussion of this is developed in Chapter 2, by critically considering how violence and abuse against older people has been framed and understood in the UK.

The focus of Chapter 2 is on how abuse against adults has been contextualised. I demonstrate the impacts this has on survivors and services' ability to recognise and respond to their violence and/or abusive situations. It seeks to show how EA is a multifaceted issue which is strongly dependent on social understandings and argues this helps shape the views and experiences of older women survivors and practitioners who support them. The chapter takes an interdisciplinary stance and considers literature from several disciplines which sheds light on how the contextualisation of EA has negatively impacted on survivors and support services. The impact of budget cuts and austerity, and how these are affected by neoliberal ideology is also discussed. It

is argued that these have presented additional challenges for services in providing effective responses to older victims.

Chapter 3 provides an overview of the existing research and official statistics that relate to victimisation against older people. Similarly, to Chapter 2, this chapter adopts an interdisciplinary approach by considering literature from several fields. The focus is on the extent and nature of victimisation against older people, the impact on them, barriers they may face to disclosure, and their support needs. Gaps in current understanding are also highlighted.

Chapter 4 details the methodology and how this links to all aspects of my research. The research questions are reiterated, and the theoretical and philosophical framework introduced in this chapter is developed**.** The study design is set out which took a qualitative approach and used un-structured interviews to gain data from both survivor's and professionals. This chapter also presents the search strategy used to obtain information, and sets out how data was collected, highlights the ethical considerations, and details the approach taken to demonstrate the validity of the research.

Chapter 5 presents the findings from interviews with older survivors (n13). The focus of these interviews was on their self-defined experiences of violence and/or abuse from the age of 60, how age and other factors impacted on their experiences of victimisation, the impact of victimisation, and the services and/or support networks they accessed.

Chapter 6 details the findings from interviews with practitioners working in DVA organisations (n11) and adult social services (n10). These interviews focused on exploring their ability to recognise and respond to violence and/or abuse, challenges faced when working with older survivors, and whether support needs of older victims differ to younger survivors.

Chapter 7 presents professionals' perspectives of the nature and impact of violence and/or abuse against older women. With the aim of providing a higher-level analysis, their accounts are linked to the stories of the 13 older women who took part in my study.

The final chapter, Chapter 8, draws the findings together and assesses them against the research questions. It also outlines the priorities for future research, and key implications for policy and practice. It highlights the key contributions to knowledge that stem from this thesis and ends with some final words.

Chapter 2: How violence and/or abuse against older people has been framed and understood in the UK

2.1: Introduction

Chapter 1 acknowledged the criticisms relating to definitions of elder abuse (EA). This chapter expands on this by critically considering how abuse against older people has been framed and understood in the UK. The purpose is to demonstrate how its contextualisation has negatively impacted on survivors and support services. As a key aim of this research is to listen to the voices of victims, and professionals who work with them, this chapter provides an essential component that facilitates understanding how their experiences and views may have been shaped by the conceptual contextualisation of EA.

To help demonstrate how EA is a multifaceted issue that is heavily contingent on social understandings (Hall, 2014), it is essential to consider various sources that have contributed to the way abuse against older people has been framed and understood. As knowledge derives from several fields (Allcock, 2018), this chapter adopts an inter-disciplinary approach that considers literature from different fields, such as EA, gerontology, nursing, social work, family violence, and public health fields. To ground the discussion, this chapter commences with a historical overview of the development of domestic violence and/or abuse (DVA), EA, and the adult protection framework. This leads on to exploring the concepts of ageism and vulnerability, and how the stigma associated with these constructs negatively impacts on survivors and practitioners. It is then argued that polices and legislation introduced by the UK Government have helped frame older victims as inherently vulnerable and impaired, who are at risk of a separate and distinct type of victimisation, and that the term EA helps reinforce and sustain this conception. To further highlight how the conceptual understanding of EA impacts on victims and support services, this chapter then sets out some key similarities and differences between DVA organisations and social services. The impact of budget cuts and austerity, and how these are impacted by neoliberal ideology is then discussed as these are key to understanding the additional challenges services face in providing effective responses to older victims. Last, a chapter summary is provided.

2.2: Historical overview of DVA, EA, and adult protection framework

In the 1970s the women's movement was instrumental in obtaining recognition of Domestic Violence (DV) as an issue (Carthy and Taylor, 2018). It is outside the ambit of this thesis to provide an in-depth historical account of this 'grassroots' movement and subsequent successes, but it is important to acknowledge that feminist interpretations of DV, now more commonly referred to as domestic abuse (DA) or interpersonal violence (IPV) were forefront in challenging psychological and family violence theories of DV (Houston, 2014). Through listening to the voices of survivors, feminist studies highlighted how violence against women was a manifestation of male power and privilege (Kelly, 1998). As a result, there has been a shift in how society thinks about DVA, and public attitudes have become less accepting of abuse within domestic and intimate relationships (Carthy and Taylor, 2018). Notwithstanding this, campaigns for empowerment neglected to acknowledge older women as victims and even when they were included, this was minimal (Kitzinger and Hunt, 1993). This arguably contributed to their invisibility. While there is now some recognition that older women can experience DVA, their experiences are still somewhat ignored (Bows, 2019a, 2019b). Although my research has chosen to focus on older women, it is worth noting there has also been scant regard afforded to older male victims (Melchiorre et al, 2016).

In the main, the UK Government have responded to DVA through a reliance on the criminal and civil justice system. Rape in marriage has been recognised as crime since 1991 (Vallithan, 2017), and since the introduction of the Crime and Disorder Act (1998) (CDA) local DV multi-agency fora were established in which criminal justice discourse was prioritised. Other policy developments include the Domestic Violence, Crime and Victims Act (2004) (DVCA) which supports victims and gives legal protection to victims of DV, the Serious Crime Act (2015) which makes controlling and coercive behaviour in an intimate or family relationship a crime (section 76), and more recently the Domestic Abuse Act 2021, which among other things creates a statutory definition for DVA.

In stark contrast, EA was initially recognised by English doctors in the mid-1970s (Penhale, 2008). The difference between medicalised recognition and the feminist 'grassroots' movement arguably impacts on how abuse against older victims has been

understood (Penhale, 2003). Unlike DVA which conceptualises abuse as an expression of male power and privilege (Kelly, 1998), the primary focus of EA is on age and vulnerability (Meyer et al, 2020). Chisnell and Kelly (2019) argue that the connection of abuse to age and vulnerability, can be linked to wider societal perceptions of older people as burdens. This attitude leads to victim blaming and older victims are consequently seen as deserving their plight. Prioritising age and vulnerability is problematic, because as explored in section 2.2.1 and 2.2.2, it negatively impacts on older victims, and effects professionals' ability to recognise and respond to older survivors (Blood, 2004; Bows and Westmarland, 2017; Harbison, 2008; McGarry and Simpson, 2010, 2011; Lazenbatt et al, 2013, 2014; SafeLives, 2016; Wydall et al, 2015).

There are also identifiable differences in terms of policy. EA was first identified in the mid-1970s, but it was not until the late 1980s that the subject started to be taken seriously by State officials (Penhale, 2008). It then took over a decade for the UK Government to indicate it was considered a problem warranting attention. They did so by publishing guidelines entitled *'No longer afraid'* (Department of Health (DoH), 1993), which sought to safeguard older people in domestic settings by encouraging local authorities (LA) to consider their own policies and procedures. Unlike responses to DVA, EA was thus positioned within a welfare adult protection framework, as opposed to a criminal and/or civil justice response, and the primary factor influencing vulnerability to exposure to violence was postulated as ageism, not gender inequalities (Meyer et al, 2020).

From the mid-1990s onwards there was debates about the need for a legislative framework for the protection of adults (Chisnell and Kelly, 2019). The Government recognised the need for action, but instead of legislating, a policy framework entitled 'No Secrets' (DoH, 2000) was issued. The policy applied to 'vulnerable adults' who were at risk of abuse. How 'vulnerable adults' were defined and issues relating to this, will be returned to later, but is imperative to note here that age was included as a factor for assessing vulnerability, albeit without providing a fixed age where 'older' commenced. 'No Secrets' gave direction to develop and implement multi-agency responses to abuse, with social services clearly identified as the leading agency. In doing so, the protection of 'vulnerable adults' was again firmly placed in the context of welfare provisions. Nevertheless, No Secrets' (DoH, 2000) did draw attention to the

importance of examining the underlying dynamics and patterns of harm because some instances of abuse will constitute a criminal harm. However, the responsibility for involving the police lay with social services. As I argue in section 2.3.4, this is concerning because social services practitioners rarely involve the criminal justice system when working with older victims (Clarke et al, 2016).

The Mental Capacity Act 2005 (MCA) was a key development in the legal and policy framework applicable to safeguarding. While it is beyond the ambit of this thesis to provide a detailed account of this Act, it is essential to note that it enshrines the presumption that adults have capacity to make decisions and a right for those decisions to be 'unwise'. This could include, for example, remaining in abusive situations, when they have capacity to make that decision. Although the MCA permits individuals to make unwise decisions, which includes remaining in relationships that put them at risk of violence and or abuse, as discussed in section 2.3.3, practitioners can apply to the Court of Protection to protect 'adults at risk' in some instances (Merry, 2018).

Following a review of 'No Secrets' (Department of Health (DoH), 2008), it was superseded by the Care Act 2014 (CA). This Act, placed on a statutory footing some of the adult protection obligations that existed previously. For example, once a safeguarding concern is reported to the LA or identified by them, they have a duty to make enquires (s42[1]), and decide what action to take (Clements, 2017). Similarly, to 'No Secrets' (DoH, 2000), social services are required to take the lead in trying to prevent abuse and neglect from occurring, making enquires, and developing and implementing a joint safeguarding strategy (Clements, 2017). As developed in sections 2.3.2, 2.3.3 and 2.3.4 this is problematic because they may not necessarily be resourced or equipped to deal with DV (McLaughlin, 2018), or DA (Clarke et al, 2012; Robbins et al, 2016; Wydall et al, 2015). Similarly, to 'No Secrets', the importance of collaborative working was emphasised under accompanying statutory guidance (DoH and SC, 2021).

Some fundamental differences can be seen since the CA was introduced. Of key relevance is that statutory guidance to the CA recognises DA as a category of abuse (Chisnell and Kelly, 2019. This is defined using the cross-government definition (see Chapter 1 for definition) (Pike and Norman, 2017). Chisnell and Kelly (2019) point out,

that while there has always been close links between safeguarding and DA, this change explicitly identified how DA must be considered within the scope of adult safeguarding. Cooper and Bruin (2017) argue that the introduction of DA present's challenges in terms of increasing understanding and awareness of this form of abuse, alongside consideration of whether it is a safeguarding issue or not, and if it is, what pathways are required to support each victim. I return to these issues in section 2.3.2 and 2.3.4 and demonstrate how they are not fully mitigated. Another difference was attention to the overall wellbeing of individuals, including the outcomes they desired through any intervention undertaken in response to safeguarding concerns (Cooper and Bruin, 2017). In doing so, the CA was heralded as representing a new priority towards personalisation, especially in relation to the importance of individual choice and control. The inherent themes within personalisation represent the ideological shift of responsibility from state-provided and funded welfare towards more privatised and individualised forms of support (Carey, 2016). To reflect the principles of choice and control it was suggested that there should be changes in terminology (Cooper et al, 2018). For instance, to avoid a paternalistic approach, it was suggested that 'adult protection' should be replaced with the term 'safeguarding', which should be built on empowerment (DoH, 2013). Further, due to the identified stigmatising properties inherent in the term 'vulnerable adult', which are discussed in section 2.2.3, the review made firm suggestions that the focus should be on risk, not vulnerability, and consequently the term 'vulnerable adult' should be replaced with 'adult at risk'. The suggested changes in definitions were embraced, but despite the changes I later argue that the prevailing discourses allied with older people, aging and vulnerability are still represented in Government policy. Before setting out how policy reflects these concepts, to showcase the problematic nature of this, it is first necessary to identify the notions of ageism and vulnerability and how these negatively impact on survivors and support services.

2.2.1: Ageism

Butler (1963) was one of the first people to characterise negative societal views and attitudes concerning older people as 'ageism'. The World Health Organization (WHO, 2021a) recognise this type of inequality as referring to the stereotypes, prejudice and discrimination towards others or oneself based on age. Typecasts of older people see them as a homogenous group who are all frail, non-contributors, and burdens to

society (Palmore, 2003). Concerns around ageist attitudes have been highlighted and challenged but negative perceptions and assumptions that devalue older people remain deeply ingrained and overwhelmingly common in societies all around the world (United Nations (UN, 2016). Ageism is still pervasive within Western society and older people are frequently not accredited importance or respect. Social discourses often dictate that ageing is a handicap which disqualifies the actor from certain activities (Pritchard-Jones, 2016). Aging is seen as something bad, something to be feared or a negative state of being, which, as explored in the next subsection, is inexorably linked to the concept of vulnerability (Jones and Powell, 2006). Like other marginalised groups, older people often must fight to have their rights recognised and can struggle for recognition of their social worth in an era that overvalues individuality, productivity, and youth (Brannelly, 2016).

Stereotypical notions relating to age can prevent some professionals from asking older people if they are experiencing abuse (Blood, 2004; SafeLives, 2016). As disclosure is more likely if survivors are offered repeated opportunities to talk, this ignorance may prevent older victims from disclosing their victimisation. A somewhat dated study examining the impact of an alteration in practices upon recording incident rates of DV, within an USA emergency room supports this view. McLeer and Anwar (1989) show that when female trauma patients were not routinely asked about DV, 5.6% identified as victims. This rose to 30% in the year following implementation of a new protocol where they were asked. 18% of the sample range were aged 61 years and older, which indicated an early sign that practitioners needed to increase their awareness of the risk to this age group and engage with them about their experiences. Ignorance is, however, particularly easy when survivors deny what is happening to them, but morally and professionally workers should continue to offer older victims the chance to discuss their situation. It is possible for this to take years, as it can take time to build up enough trust, for an older person to admit what is happening to them (Adult Directors of Adult Social Services (ADASS), 2015). However, despite this barrier, older survivors are more likely to speak up if they are provided with a safe space and opportunity to do so (Mears, 2003). It is also essential that they can expect to be believed.

Ageist views and accompanying perceptions can impact on the ability of practitioners to recognise DA against older people because it is assumed it does not occur past a certain age, with some believing it does not really affect people over 65 (SafeLives,

2016). Lazenbatt and colleagues (2013; 2014) findings support this assertion further. In their study, 18 women aged 50 and over, who were in a long-term abusive relationship, or had been, were interviewed. All 18 participants felt that most nurses and doctors did not take them seriously and, in several cases, they reported that they did not believe their situation or distress. This added to their sense of isolation, hopelessness, and fear. It is essential that older victims are taken seriously and believed so that they are not deterred from engaging with services and can access appropriate support (Wydall et al, 2015). Rather concerningly, in a review of domestic homicide (DH) carried out by Sharp-Jeffs and Kelly (2016), it was found that a failure to accurately assess and reduce the risk of IPV can have life threatening consequences. Furthermore, it has been found that due to ageist views, when DA is detected in younger years, health and social care professionals often assume it will diminish as the couple grow older (McGarry and Simpson, 2010, 2011). Considering research from the USA, these presumptions are somewhat troubling. Hightower and colleagues (2006) findings reveal that women who reported abuse by their husbands over the course of decades said it increased after retirement.

SaveLives (2016) findings suggest that ageist assumptions can cause practitioners to miss the signs of DA, even when older survivors display an array of medical issues that are all directly linked to the physical and traumatic impacts of DA. The failure to make the link is demonstrated in some SCRs. For example, a SCR examined the case of Mary Russell (aged 81) who was murdered by her husband who was 88 (Southend Safeguarding Adults Board, 2011). The SCR identified that the police, social services, and health professionals had been alerted to injuries but failed to recognise DV. The inquiry further found that because the couple were older and frail, the police were inclined to treat allegations of DV as a social care issue rather than possible crimes. Likewise, a DH review into the death of Mrs Y, a 79-year-old woman killed by her husband, found that she was not seen as a potential victim of DA by the agencies involved and established this was partly due to her age (Albiston, 2013). It was concluded that that her death could have been prevented if responses designed to protect victims of DA were considered. Recommendations were also given by the review panel, which included minimum standards for DA training across agencies. Nevertheless, as developed in section 2.3.2 it seems not all social workers receive such training (McLaughlin, 2018).

Ageism and accompanying stereotypes may impact on how cases of sexual assault on older women, are perceived or responded to (Fileborn, 2016). Connolly and colleagues (2017) propose that the ageist caricature contains a sexual myth that sees older women as sexless, rendering them as unlikely targets of sexual violence. As a result, practitioners find it hard to believe older people can be victims of sexual attacks, or capable of carrying out such acts (Bows and Westmarland, 2017). This view is further crystallised by socially constructed 'real-rape' myths which cast victims as young women who are attacked by a stranger, who is motivated by sexual gratification (Estrich, 1987). Older rape survivors do not meet the stereotype of a younger woman attacked due to her sexual desirability (Bows and Westmarland, 2017), and perpetrators are often termed gerontophilic (Ball, 1998), pathologized and seen as particularly sick or depraved. Consequently, rape and sexual violence against older women is less easy to comprehend, especially when it is compared to younger groups, and older survivors are even less likely to be believed (Bows and Westmarland, 2017). Taboos surrounding rape are also present for males, but Roberto et al (2007) argue it is even harder to consider males as victims of sexual violence, especially older men (Roberto et al, 2007).

Tying the elements of marginalisation, discrimination, and abuse in later life together Penhale and Kingston (1995) articulate how older women are subject to 'triple jeopardy'. To be old is to be marginalised (single), to be old and female is to be marginalised (double), and to be old, female, and abused is to be marginalised (triple). This three-point example facilitates explaining the intersections between age and gender and the overlaps between age (ageism) and gender (sexism). The combination of these inequalities, alongside being abused can impact on the provision of specialist services. For example, it has been highlighted that:

> *'as an abused woman everyone tells you what to do and as an older woman everyone tells you what to do; so as an older abused woman, it's a double whammy.'* (Refuge worker, as cited in, Blood, 2004, p.16)

Thus, due to ageism, DA services can fail to empower older victims (Blood, 2004; SafeLives, 2016). Recent findings support this. Carthy and Bowman (2019) found that practitioners in DV services and adult social services can assume older women are more willing to tolerate abuse. This was linked to their personal views of older survivors

who experience intimate partner abuse (IPA) Due to a void in their knowledge and practical experiences, their views were based on cognitive biases.

Deeply rooted and negative perceptions help fuel ageism and perpetuate prevailing social norms that tolerate or even condone EA, thus exacerbating many abusive situations (Help Age International (HAIa; HAIb), 2017; Penhale and Parker, 1999). Ageism is thus a mechanism that produces, sustains, and justifies abuse against older people (Biggs et al, 1995). There is an additional impact on older women who may be subjected to further marginalisation from a sexist society (Walker, 1986). Ageism and sexism merge to produce a socially constructed dependency in old age in which, as highlighted in Chapter 1, the feminisation of poverty is a key aspect (Women's Aid (Women's Aid (WA), 2019; Women's Budget Group (WBG), 2018; WHO/INPEA, 2002). These social processes are so omnipresent that older women often suffer discrimination and disadvantage, which is not only abuse in and of itself, but also renders their experiences invisible (WHO, 2002; Whittaker, 1995). Sexist attitudes convey messages that women are defined by traditional gender roles (Aitken and Griffin, 1996), and due to ageist views, older women are seen as less productive and competent overall (Crichton et al, 1999). The reinforcement of these stereotypes and social dictums can encourage older women to avoid making meaningful choices in their lives and thus when they experience abuse in relationships, they are likely to remain in them (SafeLives, 2016; Vinton, 1999).

Alternate positive narratives regarding older people are less common in public discourses (Duffy, 2017). As a result, older people are frequently exposed to negative views and treatment. In response to ageism older people can either conform to the ageist expectations of others, who they may depend on for certain services, or reject and challenge age-ascribed common perceptions (Biggs et al, 1995). There is recognised value in rejecting ageist stereotypes because people who display a more positive self-image of ageing are more likely to recognise and report EA (Aday et al, 2017). In comparison, those who accept ageist views are less likely to disclose abuse (Palmore, 2003). It is thus imperative to take steps to combat ageism by empowering older people with a full sense of purpose and awareness, accompanied with a right to lead a life without abuse (Aday et al, 2017). As discussed in Chapter 4, intersectional feminism has the potential to advance social justice goals (Burgess-Proctor, 2006) and is thus a particularly fruitful theoretical framework for my study.

2.2.2: Vulnerability

It seems well recognised that there is no single definition of vulnerability and that different polices and guidelines construct notions of vulnerable groups in various ways (Bracken-Roche, 2017). While the concept of vulnerability and consequently the criteria designating vulnerable populations remains vague, various protective guidelines stipulate special protections for vulnerable populations (Ruof, 2004). Within vulnerable groups, Brown (2011) argues that the most notable examples are children and young people, and adults who are seen as lacking capacity to protect themselves. Prominent in the latter group are older people. Ageist social constructions underline the common assumption that older people are particularly vulnerable (Jones and Powell, 2006). The association between vulnerability and old age mutually reinforces stereotypical ideas of old age itself, as well as the need for care and support, which is seen as something that should be feared and something that is bad (Pritchard-Jones, 2016). Constructions of the concept of vulnerability have manifold implications on how organisations designed to provide support treat older people (Ruof 2004). It can be assumed older victims need protection because they are inherently vulnerable and consequently decisions are made on their behalf (Lonbay, 2018).

The prevailing discourses aligned with older people, aging and vulnerability can be seen in politics, the media, and other institutions (Duffy, 2006). These socially constructed notions can cause paternalistic and oppressive actions, including State intervention, because it is presumed that those deemed vulnerable do not know what is best for them and thus require protection. This may be at odds with their human rights (Dunn et al, 2008), and is disempowering (Lonbay, 2018). Consequently, challenges have been raised concerning the way vulnerability is invoked in social policy (Sherwood-Johnson, 2013). As discussed below, the UK Government intervened through successive policies and then Legislation. These have arguably helped shape and crystallise older abused adults as inherently impaired and vulnerable, who experience a distinct type of abuse.

2.2.3: Government policies and Legislation

In England and Wales, prior to CA and Social Services and Wellbeing (Wales) Act 2014 (SSWWA) there was no single piece of legislation concerned with the protection of 'vulnerable adults'. As noted earlier 'No longer afraid' was published in 1993 and

sought to safeguard older people in domestic settings. Although ‘older’ is not defined, the view that abuse of older people should be considered *‘separately from other forms of abuse’* (DoH, 1993, pg. 1) was taken. This designated age as a primary factor to be considered when assessing vulnerability to abuse and arguably helped create the view that older people are at risk of a distinct type of victimisation. Moreover, due to the association between ageing and vulnerability (Jones and Powell, 2006), the focus on age arguably invokes notions of frail, dependent older people (Hightower et al, 2006).

Following ‘No longer afraid’, ‘No secrets’ was published (DoH, 2000), which sought to protect ‘vulnerable adults’ who were defined as someone:

> *‘[…] who is or may be in need of community care services by reason of mental health or other disability, age or illness, and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation’* (DoH, 2000, para 2.3).

This definition was also adopted by the equivalent Welsh Policy guidance on adult safeguarding, entitled, ‘In Safe Hands’ (National Assembly for Wales, 2000). In contrast, the Adult Support and Protection (Scotland) Act (2007) (ASPSA) refers to ‘adults at risk’. Pursuant to Section 3, ‘adults at risk’ are defined as people who:

> *‘(a) are unable to safeguard their own well-being, property, rights or other interest; (b) are at risk of harm; and (c) because they are affected by disability, mental disorder, illness or physical or mental infirmity, are more vulnerable to being harmed than adults who are not so affected.’*

The Scottish Government maintained that this definition avoided assumptions regarding inherent vulnerability and the stigmatising labelling of groups because all three parts of the definition must be met for a person to be classified as an ‘adult at risk’ (Sherwood-Johnson, 2013). However, the legislation still links the inability to protect oneself from harm to an impairment, which, as argued below, is problematic.

‘Vulnerable adults’ (England and Wales) and ‘adults at risk’ (Scotland) are defined as someone who has a cognitive or physical impairment, who may be at threat of abuse. Thus, the approach taken by policy in England and Wales, and Statute in Scotland presents vulnerability of risk of abuse as stemming from inherent characteristics (Pritchard-Jones, 2016). This deterministic approach is often referred to as the status-

based approach (Dunn et al, 2008) and has been rejected as unsuitable, paternalistic, and stigmatising for people with impairments (Whitelock, 2009; Keywood, 2017). Pritchard-Jones (2016) argues that linking vulnerability to, for example, a cognitive impairment or age, strengthens the notion that being vulnerable is a negative thing, a flaw, a weakness. Persons with impairments are seen as passive, helpless, and incapable (Pritchard-Jones, 2018). This leads to victim blaming (DoH, 2009; Office of the Public Guardian [OPG] 2015; Sherwood-Johnson, 2013). Moreover, there is little or no analysis of other factors that may contribute to the experience of vulnerability. Clements (2011) reiterates these criticisms and adds that defining vulnerability as linked to inherent 'flaws' fails to recognise it might be the context, the setting or the place which makes a person vulnerable. This could exclude many victims. For example, a healthy and active 70-year-old woman who experiences violence and/or abuse might not qualify for support, while a survivor half their age might be offered safeguarding measures on account of, for example, a cognitive need (Blood, 2004). The various factors that connect to an increased risk, and experiences of victimisation are discussed in Chapter 3. However, it is noteworthy here, that consideration of these adds weight to Clements (2011) argument because they indicate that women's experience of vulnerability can be compounded by different intersecting layers, including gender, poverty, ageism, sexuality, social isolation, geographic location, and lack of facilities. Nevertheless, a somewhat narrow view of vulnerability is taken and consequently victims of DA are unlikely to qualify for Statutory support based on their experiences of abuse alone (Robbins et al, 2016).

As noted earlier the review of no secrets (DoH, 2008) made firm suggestions that the focus should be on risk and consequently the term 'vulnerable adult' should be replaced with 'adult at risk'. This was recognised as necessary to avoid stigmatising and because the term 'vulnerable adult' locates the cause of abuse with the victim, rather than assigning responsibility with the actions or omissions of others (OPG, 2015). Following the review (DoH, 2008), both the CA and the SSWWA came into force. Alongside legislating on the protection of adults for the first time in England and Wales, both Acts adopted the term *'adult at risk'*. 'Adult at risk' are defined as someone who:

> *'has needs for care and support (whether or not the authority is meeting any of those needs); is experiencing, or is at risk of, abuse or neglect; and as a result*

> *of those care and support neds is unable to protect themselves from either the risk of, or the experience of, abuse or neglect.'* (CA, s42(1); SSWWA, s126(1)).

Although the CA and SSWWA were heralded as moving away from blaming victims for their abuse, the way 'adult at risk' is defined leads to the inevitable interpretation that if a person has care and support needs, they are unable to protect themselves from harm. Consequently, the idea that the risk of abuse or neglect is grounded in an impairment of some form remains (Pritchard-Jones, 2018). This status-based approach is also evident in the ASPA (Sherwood-Johnson, 2013). Consequently, England, Wales, and Scotland all explicitly link the inability to protect oneself from abuse to an impairment, which is an outmoded and inappropriate stance (Pritchard-Jones, 2016). The Acts provide a legal tool that feasibly reinforces the stigma associated with physical and cognitive impairments which sees such persons as weak, or to blame for their abuse (Pritchard-Jones, 2018). Further, Lonbay (2018) argues safeguarding those who are unable to protect themselves due to their needs for care and support, positions them as dependent on others to safeguard or protect them from harm. When people are viewed as weak, helpless, and dependent, interventions tend to be inappropriate because they are overly paternalistic (Pritchard-Jones, 2016). Additionally, professionals can fail to either listen to individuals wishes or forsake considering them in their entirety, because it is assumed they do not know what is best for them (Dunn et al, 2008). Due to ageism this has potentially greater implications for older 'at risk' adults and may mean their decision making is more easily scrutinised than younger adults with care and support needs (Pritchard - Jones, 2018). Consequently, the adult safeguarding process becomes something that is done to them (Whitelock, 2009), as opposed to a process in which they actively involved in (Lonbay, 2018). Furthermore, depicting people as vulnerable puts them at risk of being seen as 'others' who are worthy of pity (Ruof, 2004). Consequently, the label vulnerable can act to exclude, stigmatise, and segregate individuals, which further entrenches inequalities (Brown, 2011). It is imperative to take to task this socially constructed label and associated stereotypes because the ingrained discourses relating to older people can fuel abusive situations and acts against their resolution (Penhale, 2003).

Previously age was a factor when considering whether an adult was a 'vulnerable adult', but now older adults are assessed in the same way as all other adults (Clements et al, 2017). While age is not a feature in the definitions under the CA and SSWWA, and was never present in the ASPA, as people age, they are more likely to develop long term health conditions and need more health and social care (National Health Service (NHS), n.d). Recent research indicates that anxiety disorders, severe depression, and lifetime alcohol disorders are common for those aged 65 and over (Buchtemann et al, 2012; Skogg, 2011; Volkert et al, 2013). Also, in 2014, the Alzheimer Society predicted that 1 in 14 of those aged 65 and over will be diagnosed with dementia. Thus, from a purely statistical perspective when definitions of 'vulnerable adults', now 'adults at risk', are based on care and support needs, it impacts more on older people. Moreover, due to the link between vulnerability and ageing (Jones and Powell, 2006), age is still arguably inferred by legislative definitions. In turn this potentially creates the impression that the adult protection framework only applies to adults who are seen as 'older' or at the least that they should be treated differently from younger adults with care and support needs.

It is essential to acknowledge that some professionals are more progressive or critical and try to change systems and aim to empower those with less power (Chenoweth and McAuliffe, 2015). This approach is essential not only to promote older people's voices being heard, but also at a societal level, because social workers play a key role in challenging ageism:

> *'…social workers are key players in defining how society thinks about and treats older people and critical social workers will be those most likely to engage with these issues and to collectively chip away at challenging ageist discourses in their workplaces that deliver services to older people and provide alternate narratives that empower older people and their families and friends to think about ageing in a much more liberating and empowering way.'* (Duffy, 2017, pp. 2074)

As explored in Chapter 4, intersectional feminism challenges inequalities and has the potential to advance social justice goals (Bernard, 2020, Burgess-Proctor, 2006). Arguably it is therefore an ideal perspective for social workers to base their practices upon, alongside being a beneficial lens for my research. Nevertheless, Mendes (2009)

argues that conventional social work practices are the most dominant in social work settings and critical practice is in the minority.

Government policy and legislation has arguably helped frame older adult victims as inherently vulnerable and impaired, who are at risk of a distinct type of victimisation. While the term EA has not been used by the UK Government to define abuse of older adults, as noted in Chapter 1, EA seems to be the most frequently employed term used in research (De Donder et al, 2011; Yon et al, 2017). As developed below, the term EA helps reinforce and sustain the idea that older victims are inherently vulnerable and impaired, who are at risk of a different type of victimisation.

2.2.4: Definitions of EA

Although there is an absence of standard definitions, it has been suggested that one key concept central to definitions of EA, is that it involves an act or omission resulting in harm to an older person (Johannesen et al, 2013). This can be identified in an early definition, developed in the UK:

> *'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'* (Action on Elder Abuse (AoEA), 1995)

This description was later adopted by the WHO in their Toronto declaration (2002). While older is not defined, research generally conceives of older people as being at least 50 and above (Baker et al, 2009; Council on the Ageing et al, 2000), and most studies adopt 60 as their starting point when examining EA (Yon et al, 2017). Irrespective of where 'old age' is seen as starting, the focus of definitions is on age (Johannesen et al, 2013). This reinforces the view that abuse of older people should be considered separately from other forms of abuse. Hightower and colleagues (2006) are critical of this because the image sustained by focusing on age conjures up notions of frail, dependent older people. The problematic nature of framing older people in this way is highlighted in sections 2.2.1, 2.2.2 and 2.2.3.

The focus on age has arguably helped shape how EA is examined by researchers. Studies exploring the phenomena are mainly approached through the health and social science frameworks which ignore how gender and power relations between individuals might contribute to victimisation (Hightower, 2006; Nerenburg, 2002).

Whittaker (1996) argues that failing to consider the relationship between age, gender and violence neutralises the fact that more older women experience abuse than men. Consequently, there is a failure to capture the realities of the lives of abused older women. When older women's voices are excluded from the DVA discourse, it is almost impossible to develop appropriate responses that meet their needs (Straka and Montimy, 2006). Mears and Sergent (2002) argue that because EA is gender blind and focuses on age and vulnerability, older women experiencing DV are marginalised, their experiences are medicalised, and inappropriate solutions are applied. For instance, they are more likely to be referred to social services instead of being signposted to DVA and/or specialist sexual support services (Scott et al, 2004, Wydall et al, 2015). Consequently, it has been argued that there is a need to examine EA through a feminist lens, which permits an examination of gender inequality and how it impacts on victimisation (Nurenberg, 2002). My study addresses this by adopting an intersectional feminist lens.

When abuse is committed in institutions it has long been proposed that victimisation remains invisible because they are mainly female spaces where ageism and sexism coverage (Griffin et al, 1999). Yet, research examining abuse in such settings is limited (Yon et al, 2018) and it seems there is an absence of studies exploring how power and control might operate within them. This is despite recognition that research and subsequent analysis might find some interesting areas of comparison between domestic and institutional settings when considering the nature and effects of power within different abusive relationships and settings (Penhale, 2003). My study ameliorates this by considering how power is exercised over others in different relationships and settings.

So far it has been demonstrated that policy initiatives and definitions of EA have helped shape and crystallise the view that older victims are inherently vulnerable and impaired who are at risk of abuse due to this. It has further been shown that this negatively impacts on older survivors, and how services respond to them. For victims of DV, Scott and colleagues (2004) concluded that older women's experiences are viewed as EA, and as a result they more likely to be supported via the adult protection safeguarding route, which as returned to in section 2.3.5 fails to meet their needs. However, Penhale (2003) points out that while there are similarities between EA and DV, there are differences too.

2.3: Key similarities and differences between DVA and EA

In many cases of violence and/or abuse in later life, perpetrators exert power and control over their victims (Spangler and Brandl, 2007). The role of power has been widely recognised, theorised, and researched when DVA is experienced by younger groups, but there is an absence of relevant theory and research that underpins understanding different forms of abuse for older people (Norrie et al, 2014). In the context of safeguarding, matters are clouded because it includes various types of abuse in different settings (Kalaga, 2004). It is important to understand the role of power because how it operates dictates different responses different responses (Penhale, 2003).

The purpose of this section is to detail the key similarities and differences between DVA organisations and social services in connection with older survivors. Exploring the similarities and differences assists in understanding the link between EA and DVA and how the conceptual understandings of both impact on older victims and practitioners in support services. Additionally, it helps build a foundation to examine how the role of power operates in different situations, thus providing some of the necessary structure required for analysing my findings.

2.3.1: Types of abuse and perpetrators

DVA includes different types of abuse including, physical, sexual, psychological and or emotional, financial and or economic, harassment and stalking, modern slavery, and coercive control (WA, 2021c). While women (and men) can experience these at any points in their life, as already established DVA has been typecast as a problem that only affects younger women (Bows, 2019a).

EA includes all the types of behaviours which are included in the definition of DVA, but also includes additional behaviours. Pursuant to Statutory guidance to the CA, abuse includes physical, DA, sexual, psychological, financial, or material, modern slavery, discriminatory, organisational, neglect and acts of omission, and self-neglect (DoH and Social Care (SC), 2020). While younger people with care and support needs can also experience these types, I argue that the adult protection framework, the term EA, and societal norms help frame an understanding that abuse against adults is a separate and distinct type of abuse that only impacts on older people. Furthermore, as

developed in Chapter 3, the Safeguarding Adults Collection (SAC) indicates that those aged 65 and above are more likely to be subjected to a safeguarding enquiry in comparison to younger people with care and support needs (NHS Digital 2018, 2019, 2020, 2021). Thus, while social services remit can and does include adults aged 18 and above, safeguarding measures are more likely for older adults, which feasibly helps reinforce the idea that EA is a distinct type of abuse.

EA occurs in a wide range of relationships in comparison to DVA. For an incident or pattern of incidents to amount to DVA, the perpetrator must be an intimate partner (past or present) or a family member (HO, 2013). Consequently, individuals such as domically care workers, strangers, and friends are excluded. In contrast, EA has long been recognised as including these wider perpetrators (Penhale, 2008), and since 'No Secrets' includes:

> *'(…) a wide range of people including relatives and family members, professional staff, paid care workers, volunteers, other service users, neighbours, friends and associates, people who deliberately exploit vulnerable people and strangers.'* (DoH, 2000, pg. 2.10).

Preparators can operate either in community settings or institutions, whereas for DVA acts take place in the community and usually within the home. Thus, the remit of safeguarding is wider and covers victimisation that occurs within institutional settings and the community (Chisnell and Kelly, 2019). A safeguarding concern is a sign of suspected abuse or neglect that is reported to the LA or identified by them. A concern can be reported by organisations and/or lay people A safeguarding enquiry is the action that is taken or instigated, in response to the concern. When abuse is committed in the community, enquires can include, for example, accusations of abuse by domiciliary care workers. As noted in Chapter 1, for brevity, I refer to victimisation that does not meet the definition of DVA, as non-domestic abuse (NDA). Younger people with care and support needs are recognised as 'vulnerable' to abuse by the previously listed perpetrators. Nonetheless, as argued earlier, the adult protection framework, the term EA, and cultural understandings of abuse arguably reinforce the idea that victimisation against older people is different. In turn, this, alongside ageist attitudes, seems to lead to professionals pursing the safeguarding route when older women disclose abuse, as opposed to contacting specialist DVA and/or sexual violence

organisations (Bows, 2017b; Scott et al, 2004; Wydall, 2015). This is problematic because as discussed in the following section social workers often have little or no training on DVA (McLaughlin, 2018).

Kalaga (2004) argues that our understanding of safeguarding adults has been complicated by its wide remit, which as detailed above, includes the abuse of adults with diverse health and social care needs who experience victimisation in a wide range of settings, and in numerous relationships. While it is possible there are differences between the causes, intent, and impact of abuse by staff in care homes towards people with health needs, and a grandson coercing his grandparents into giving him all their savings, there is an absence of relevant theory and research that underpins understanding the different forms of abuse (Norrie et al, 2014). This includes an absence of knowledge regarding how power operates between those being abused and those who abuse (Ingram, 2016). In some situations, it is however somewhat evident that perpetrators are not exercising power and control (Spangler and Brandl, 2007). For instance, due to a physical or mental condition someone might display challenging, aggressive, and often abusive behaviours, which they have no control over. This requires a different response from how DVA cases are dealt with. It is thus vital to explore how power operates in abusive situations because its role requires different responses (Penhale, 2003).

2.3.2 Training

There is scare research exploring professionals' experiences of working with older victims (Bowen and Searle, 2019; Carthy, et al, 2019) and thus little is known about what training they receive. Any organisation that has 'direct contact' with 'vulnerable adults' (SAFE Community Interest Company, 2018), receives adult safeguarding training, which includes social services and DVA organisations. Adult safeguarding training typically includes information on relevant legislation, types of abuse, mental capacity, and disclosures and responses to them (CPD Online College, n.d). Although this training might include reference to how older people could be vulnerable and highlight DVA as a type of abuse, it does not specifically focus on these matters (ADASS, 2015). Arguably, therefore, any knowledge and learning gained does not help inform the working practices of social workers and DVA organisations when they encounter older victims.

The absence of specific training that covers older victims can cause issues for DVA practitioners. Available evidence suggests they often lack the vital skills and knowledge required to confidently deal with victimisation against older groups (Save Lives, 2016a). Professionals from specialist organisations are not necessarily trained to understand abuse against older women or the additional effects on physical and mental health they might suffer (Bows, 2017a; Carthy and Bowman, 2019; Shiel, 2016). In, Bows (2017b) study, one trauma counsellor working with older survivors of sexual violence commented on his lack of experience in dealing with victims over 60 and felt some training or research should exist, that he could turn to for support. Similarly, respondents in Carthy and Bowman (2019) study, which included older adult services and DV practitioners, felt less confident in their ability to support older survivors because they had little concrete knowledge or guidance to draw on to reliably inform their working practice. They welcomed the idea of specific training in IPA against older women.

Alongside a lack of training that focuses on older victims, social workers seem to have little or no training on DVA. McLaughlin and colleagues (2018) interviewed 20 adult social workers. They found some respondents had received no DV training, others claimed it only occurred as part of their qualifying course, and some had completed a two-hour online course. Only a small minority had completed further training. All 20 participants agreed that training would be beneficial. In contrast, when social workers work in children services, DVA training is mandatory because the potential damage of children witnessing it has long been acknowledged (Robbin et al, 2016). Peckover (2014) argues this helps frame DA as primarily a child protection issue. Consequently, the absence of compulsory training for social workers in adult protection reinforces the construction of DVA as a child protection issue, which particularly impacts on older women as they are less likely to have dependent children (Robbins et al, 2016).

A lack of training seems to impact on social workers ability to identify abuse. In a study examining responses of 212 social workers, it was found that they were less likely to identify IPA when survivors were older, and when abuse was psychological (Yechezkel and Ayalon, 2013). The inability to identify psychological abuse is more likely to impact on older people. Research from beyond the UK has consistently found that physical and sexual DA decreases with age, but psychological and non-violent

abusive behaviours continue and often escalate (Lundy and Grossman, 2009; Stockl et al, 2012; Zink et al, 2005; Zink et al, 2006). Further, in a systematic review of literature, it has been found that psychological abuse is a common experience for older women (Finfgeld-Connett, 2014). Therefore, the inability to identify emotional/psychological abuse arguably impacts on older people to a greater extent because they are more likely to experience this type of abuse. If abuse is not recognised it can leave survivors in vulnerable situations with little or no help (Robbins et al, 2016). This potentially increases their suffering. Lazenbatt and colleagues (2013, 2014) suggest that psychological abuse is more effective in controlling older women and increasing their uncertainty about themselves and their ability to cope. Furthermore, Wydall and colleagues (2015) argue that the failure to identify DA impacts on prevalence data which adds to the systematic invisibility of older survivors which can subsequently impact on service developments. This in turn helps shape and crystallise the notion that older people do not experience DVA which could subsequently be used to justify a lack of specific mandatory training. Training is essential because it aids risk identification (Sharp -Jeffs and Kelly, 2016).

Unlike DVA organisations social services have a duty to investigate enquires (s42[1]), and to decide what action should be taken (Clements, 2017). It is acknowledged by Manthorpe and Bowes (2016) that to assist in enquiries from the police, regulators, commissioners and professional bodies, social workers will need to develop or refine their forensic skills of evidence collection, synthesis, and analysis, alongside ensuring accurate, high-quality recording to improve the quality of reports. This is essential to support staff, families, and adults at risk. However, time constraints and heavy caseloads are reported as common by social workers (Lonbay, 2018) and consequently it may be somewhat difficult to acquire or improve their skills and effectively safeguard victims in both community settings and institutions.

2.3.3: Risk assessment

Risk of victimisation is measured by assessing factors that increase the chances of experiencing violence and/or abuse. DVA organisations and social services both use risk assessment tools with the aim of avoiding and minimising identified risks (Pillemer, 2016; White, 2017). Nevertheless, how they assess risk varies. The purpose of this

section is to delineate how risk assessment has been approached by DVA services and social services when working with older victims.

To assess risk DVA organisations utilise Domestic Abuse Stalking Harassment risk assessment checklist (DASH) and receive training to do so (DASH riskmodel, 2021, n.p). DASH is seen as a vital means for assessing the risk posed by DA because it has been specifically designed for this purpose (Wydall et al 2015). It consists of 27 questions and can help save and change lives through early identification, intervention, and prevention, and is a resource that can be used by all professionals in public protection, including adult safeguarding (DASH Risk Model, 2021, np). It is essential to gain accredited training to understand DASH as without this, mistakes can be made (DASH riskmodel, 2021, n.p). A failure to use DASH or use it correctly has been highlighted as having potential life-threatening consequences (Sharp -Jeffs et al, 2016). Despite its benefits, DASH has its setbacks. It has been criticised for having fewer questions that are relevant for older survivors (Chisnell and Kelly, 2019). In an evaluation of the Access to Justice pilot project, which was implemented in Wales, it was recognised by some social workers that DASH might need adapting slightly to meet the needs of older victims (Clarke et al, 2012). To test this, an adapted version was developed and social service personnel were trained in its use. Only six adapted forms were completed during the pilot. Consequently, it is hard to draw any firm conclusions if the adapted tool provided a more accurate measure of risk in the context of DA against older people. Since this pilot project, it seems little consideration has been given to the suitability of DASH for older victims. In contrast, there has been work carried out to understand how young people experience and respond to DA and how they best engage with practitioners (SafeLives, n.d). This led to a young person's risk identification checklist that is accompanied by practice guidance. Despite recognition by some social workers that DASH needs to be slightly adapted, other research suggests that very few have knowledge of the DASH process, and most fail to identify DA as a social work issue (Robbins et al, 2016). It has also been suggested that they have limited knowledge and thus inadequate application of DASH, or an unwillingness to use it, to assess older victims of DA (Clarke et al, 2012; Wydall et al, 2016). Due to the fatal risk this poses, Sharp-Jeffs and Kelly (2016) concluded that social workers should receive training on DA risk assessment to enable them to effectively utilise DASH. Moreover, the use of DASH facilitates referrals of high-risk

cases to a multi-agency risk assessment conference (MARAC) (Wydall et al, 2018). The absence of older people in MARAC has been identified as contributing to the systemic invisibility of older DA victims (SafeLives, 2016). Consequently, by failing to use DASH or use it effectively, the practices of social workers place older people at risk and arguably helps further shape and crystallise the notion that older groups do not experience DVA.

The limited knowledge of DASH and its application, or the unwillingness to use it, and the belief that DVA is not a matter for social workers to deal with, is arguably reinforced by risk assessment guidance, provided by the Social Care Institute for Excellence (SCIE, 2020a). Instead of developing risk assessment tools that specifically measure different types of risk, social service workers are provided with a framework on how to assess risk. This starts with identifying the risk, and then assessing the risk in view of its impact and likelihood of occurrence. Within the risk identification stage, social workers are required to identify both the potential benefits and harms of a given action, decision, behaviour and so forth. Once there is clarity on these matters, practitioners assess the impact and likelihood of the potential benefits and harms identified. Other than stipulating that the potential benefits and harms must be seen from the individual's point of view, there is guidance of what harm is. The lack of guidance as to what constitutes harm is also seen in Government responses to abuse and neglect against older people. The first UK policy, 'No longer afraid' (DoH, 1993), and the ASPSA both include the concept of harm as a key ingredient to establish abuse, but there is no indication of what harm is or means. 'No Secrets' (DoH & SC, 2000) retained the notion of harm, but increased the threshold to 'significant harm'. Nevertheless, there was no explanation of what 'significant' was, providing only that harm:

> *'…should be taken to include not only ill treatment (including sexual abuse and forms of ill treatment which are not physical), but also the impairment of, or an avoidable deterioration in, physical, intellectual, emotional, social or behavioural development.'* (DoH, 2000, section 2.18)

As significant harm is not defined explicitly, it is open to various interpretations. Later Government enactment clouded matters further. Not only did the CA repeal 'No Secrets', thus rendering its associated concepts seemingly unusable, but it also abandoned the concept of harm. Instead, types of abuse are provided, but this does not clarify what level of harm needs to be reached before action or intervention is required. Whilst small variations might be understandable, it has been found that current practice leads to a wide variation in threshold decisions and an uncertainty of how to address these fluctuations (Wydall et al, 2015). The need for social workers to have a clear understanding of thresholds, was identified in a serious case review (SCR), following the death of Steven Hoskins in 2006, who was tortured and drugged before being murdered (Cornwall Adult Social Care. Adult Protection Committee, 2007). Despite this recognition, there is no National standard. Instead, it is left to the professional judgement of the assessing social worker, typically working within thresholds defined by their employing local authority (Chisnell and Kelly, 2019). For example, in the Northeast (where my research mainly took place), in 2011, ADASS North East produced regional guidance. This practice tool was designed to:

> *'consider types of abuse, examples of abuse which sit outside of the safeguarding framework and those that sit inside the framework and require significant or critical assessment/investigation under safeguarding procedures.'* (ADASS, 2011, p. 3)

The guidance identifies types of abuse and the levels they can occur at, ranging from lower-level harm through to critical. In situations when low level harm is identified, the practice tool stipulates that it should usually be addressed through internal procedures. Whenever there is significant harm or very significant harm, a referral to safeguarding should be made and addressed under safeguarding procedures. In critical cases, matters should be addressed as potential criminal harms. While this practice tool may offer some assistance, it does not recognise DVA as a category of abuse. Further, practitioners are encouraged to use their professional judgment. In the context of DVA, this is problematic because social workers frequently fail to identify DA as a social work issue or have piecemeal understandings of it (Robbins et al, 2016). Moreover, as discussed in section 2.3.2, very few are trained to understand the complexities of DVA (McLaughlin et al, 2018), and they are less likely to identify IPA when survivors are older (Yechezkel and Ayalon, 2013).

There is emphasis placed on understanding the person's wishes and feelings in relation to the risk, which is further strengthened by the MCA (White, 2017). If an individual has capacity and decides to make an 'unwise' decision, including remaining in an abusive situation, this must be considered. It is outside the ambit of this thesis to discuss exceptions to this, but it is noteworthy that practitioners can apply to the Court of Protection to, for example, remove an older victim from their abusive partner. Even if victims have capacity, obiter comments in 'NCC v PB and TB' (2014) suggests the Court can invoke inherent jurisdiction and authorise, in this case removal of the victim from her home. Further, guidance by Merry (2018) on the use of inherent jurisdiction highlights how practitioners can apply to the Court of Protection to safeguard 'adults at risk', even when they have capacity, and the ruling in 'A Local Authority v DL, RL and ML' (2010) supports this contention. There are debates surrounding the use of the Court of Protection, which centre on how courts tend to rely on outdated concepts of vulnerability, which Pritchard-Jones (2016) argues is concerning. It could lead to, for example, automatically tying vulnerability and old age together ('Local Authority X v MM and KM', 2007). The problems with assuming vulnerability and age are connected was explored in sections 2.2.1, 2.2.2 and 2.2.3. Pritchard-Jones (2016) also argues that this approach fails to consider multiple sources of particular experiences of vulnerability. This might include gender, race, geographic location, and lack of facilities. The ignorance of other factors potentially places older people at risk of inadequate responses.

Concerns around assessing capacity in DA situations have been raised by Local Government Association (LAG) and ADASS (2014), as it can be particularly challenging. Under the CA practitioners are required to promote wellbeing (Penfold, 2017). The wellbeing principle is a broad concept and relates to several areas including treating individuals with respect, protection from abuse and neglect, control by the individual over their day-to-day life, and the individual's contribution to society (SCIE, 2020b). Robbins and colleagues (2014) argue that the requirement to promote wellbeing and support people to have control over their lives, which promotes autonomy and free will, becomes clouded in the context of DV. In these situations, research by Hoyle and Saunders (2000) demonstrates that victims of DA are frequently unable to provide consent for interventions because they are unduly influenced by perpetrators, who control their access to external support.

Consequently, their refusal for support is not based on their autonomous free will, but instead on the power and control asserted over them. It seems, however, that social workers tend to focus on capacity and accept a refusal for further action (Robbins, 2016). This is very concerning as it can leave victims in very risky and very dangerous situations with no support. Consequently, assuming people are making informed choices because they have capacity, is fraught with difficulty and requires more discussion and training (McLaughlin, 2018).

Services supporting victims of DVA do not seem to have a threshold that must be met before support is provided (WA, 2021c). It is implied that so long as someone is or has experienced DVA, they can access specialist support services, even if their risk level is low. However, due to cuts in funding, it is possible that services may have to operate on a 'more at risk' based level. According to Towers and Walby (2012), LA funding for specialist services was cut by 31% in 2010-2011, and WA (2018) report that 11,867 referrals to refuge services in England were declined in 2016-2017, mainly due to a lack of space. With a lack of funding and spaces, it seems practices are implemented that prioritise access to those deemed higher risk (Robbins, 2015). Higher risk situations, which are often discussed at MARAC rarely include older peoples' cases (SafeLives, 2016). As a result, refuges are less likely to be aware of DVA cases for older victims, and any polices that operate a 'high risk' approach are more likely to impact on older people.

2.3.4: Interventions

Intervention is *'the act of intervening, especially to influence or alter a situation'* (HarperCollins, 2008, p. 448). In the context of services, interventions are actions professionals initiate to assist those they support. The purpose of this section is to examine what is known about interventions DVA services and social workers implement when working with older survivors.

Specialist support services often deliver interventions themselves but can also refer to other organisations to assist with ancillary matters such as gaining suitable housing and resolving debt (Refuge, n.d). It is broadly accepted that DVA is underpinned by the aim to exert power and control over another (Rogers and Taylor, 2019). Consequently, when delivering interventions there is an emphasis on empowerment

(Shiel, 2016). Empowerment aims to guide people towards achieving a sense of control and promotes their personal, interpersonal, and political and social power by increasing skills, knowledge, and access to resources (Cavalieri, 2018). In line with this, the delivery of services is focused on developing survivors' skills for living a safe and independent life in the future (Shiel, 2016). Interventions have however been aimed at supporting younger survivors and their children (Blood, 2004, McGarry et al, 2014, SafeLives, 2016, Scott et al, 2004). Thus, it has been recommended that services should adopt an intersectional approach, which would include considering the acute barriers older women might face (Jeraj, 2013). However, Carthy and Taylor (2018) suggest their needs are rarely considered in current specialist DA service provisions. Practitioners in their study believed current services were created around the needs of younger women and children. Similar findings were reported in an earlier study in Scotland, by Scott and colleagues (2004). Consequently, when older women do access services, they are unlikely to be supported in the most appropriate and effective way. Also, when the first refuge opened in 1971, it was not set up and designed with younger women in mind (Blood, 2004, McGarry et al, 2014, SafeLives, 2016). Due to ageist notions, little has been done to resolve this (Scott et al, 2004; Shiel, 2016). As a result, refuge accommodation often lacks amenities for those with ageing and older life health issues or physical or cognitive issues. There may, for example, be practical issues due to disability and mobility needs. While younger women can also have disabilities, data from SaveLives (2016a) highlights the acute impact on older women. 48% of people aged over 60, report some form of disability, compared to 13% of younger victims. Furthermore, refuges tend to be noisy and chaotic because there are high numbers of children residing in them (Blood, 2004). This can cause older women stress, while others cannot tolerate it at all. Due to this and a lack of tailored amenities, refuges are *'totally unsuitable for older women'* (Participant 13, as cited in McGarry et al, 2014, p. 208). Consequently, older women are often not supported effectively by specialist agencies (Shiel, 2016), and often require tailored support.

A key difference between DVA organisations and social services, is that social workers never deliver interventions themselves (Chisnell and Kelly, 2019). Instead, they investigate concerns and can refer or signpost to other services. Since the CA, social workers must focus on the overall wellbeing of the person, including the outcomes

they wish to achieve through any interventions undertaken in response to safeguarding concerns (Cooper and Bruin, 2017). This applies to both DVA and NDA. Research exploring how social services respond to NDA is somewhat lacking. In rare exception to this, Lonbay (2018) suggests that due to widespread ageism which undermines older people's autonomy, erodes personhood, and perpetuates paternalistic discourse, older people are considered as inherently vulnerable. As a result, their opportunities to be engaged in adult-safeguarding processes are reduced and rather than being empowered and involved, decisions are made on their behalf. It is unclear if the findings include DVA, and NDA, and abuse within institutions. For care settings, academics offer some insight here. Chisnell and Kelly (2019) highlight that often, because concerns involve deficiencies in the quality of care provided, the focus is on service improvements, such as appropriate staff training, and less likely to directly involve the service user.

Research examining the responses of social workers when they are tasked with safeguarding older DVA victims is limited. There is however some understanding of this. Yechezkel and Ayalon (2013) findings indicate that social workers tend to prefer legal interventions for older victims of IPA, and therapeutic ones for younger survivors. Other findings contradict this. Clarke and colleagues (2016) found that practitioners, including social service workers fail to discuss criminal or civil justice options with survivors of DA. Practitioners commonly assumed that it:

'would be detrimental to the general health and wellbeing of the older person' (pg.216).

This view casts older people as a homogenous group and can arguably be construed as paternalistic and ageist. Such stereotyping fails to offer older victims the opportunity to have their voice heard through the criminal justice system. Notwithstanding this, pursuing matters through formal legal measures might not always be an appropriate course of action. It has been recognised that many survivors do not want to subject perpetrators, who are family members to criminal proceedings (Kelly, 1999, MirrlessBlack, 1999). However, older victims should not be denied redress if this is the route they wish to take. There is an absence of research exploring support given to victims of NDA, who may have reason to seek criminal or civil justice options. In institutional settings the victim will inevitably have physical and/or cognitive health issues (Oliver, 2016). Given the way EA has been framed and understood, it is

likely practitioners would assume they would be too ‘vulnerable’ to face legal interventions. As explored in section 2.2, 2.2.3 and 2.2.4, EA has been positioned within a welfare discourse, which gives rise to the idea that all older people are inherently vulnerable. A welfarist approach is likely to encourage a view that prosecuting cases is not in the ‘public interest’ because it avoids exposing older survivors to the criminal justice (Clarke et al, 2016). Further, this approach, alongside a lack of training and knowledge may deter social workers from referring older survivors to specialist DVA and/or sexual violence organisations. A discourse is propagated whereby DVA is constructed as an issue falling outside the remit of adult social services (Robbins et al, 2016), and thus practitioners are unaware of vital information. For instance, Carthy and Bowman (2019) found that social workers are not provided with information on possible pathways for older women experiencing IPA. This makes it somewhat impossible for them to be able to refer older women to specialist support.

Ideal responses to a disclosure of abuse are postulated as seeking to empower the victim through the provision of non-judgemental support and information, which includes signposting or referring to specialist DVA support services (Pike and Norman, 2017). Robbins and colleagues (2016) highlight that although DA is an adult social work issue, this must be tempered with an awareness that this might not be the single charge of social workers. Consequently, it is essential that they gain further advice and expertise from specialist agencies. Despite this recognition, there is evidence that joint working is lacking. Bows (2017b) interviewed 23 practitioners supporting older survivors of sexual violence and found that none of the referrals had come from adult safeguarding services. Furthermore, the CDA (1998) brought together relevant agencies at a local level, with the aim of improving multi -agency working to reduce crime, including DVA. There is evidence that many of these crime and disorder reduction partnerships experience issues in ensuring appropriate staff from all relevant agencies are represented, and a lack of engagement by some, including social services (Home Affairs Committee, 2010). Thus, despite statutory guidance to the CA emphasising ‘*working together’,* it seems collaborative practices, is lacking. To work together effectively it is essential to share data. However, there is evidence suggesting that practitioners from various fields, including adult social care are sometimes uncertain about formal data sharing protocols (Wydall et al, 2015). This

was highlighted as a potential barrier in providing effective support for older victims because highly relevant information was not passed on to key agencies.

Due to a lack of understanding of DVA, the lack of joined up working is likely to impact on the support given to older victims by social services and their needs are unlikely to be fully addressed. For example, Khalil (2013) argues that adult safeguarding workers often try to manage DA cases by using social care interventions, meaning the most effective option is missed. This suggests that they do not signpost to DVA and/or sexual violence organisations, but there seems to be no empirical research supporting this contention. This is addressed by my research as it seeks to unearth the types of interventions social services initiate when working with older survivors. The use of social care interventions in DVA cases is inappropriate as they do not address power and control dynamics and leaves women in potentially very risky and dangerous situations. Women experiencing DVA are particularly vulnerable during help-seeking or when they are leaving an abusive relationship (Carthy and Bowman, 2019). This is when they are most at risk to serious harm or fatal violence (WA, n.d). At least 41% of women killed by their ex-partner in 2018, were killed within the first month of separation and 89% in the first year (Long et al, 2020). The inability to make appropriate referrals to specialist organisations that are experts in safety planning, potentially leaves victims in vulnerable situations with little or no support (Robbins et al, 2016; SafeLives, 2016), which can cause fatalities (Sharp-Jeffs and Kelly, 2016).

2.4: Austerity, social funding cuts, and neoliberal ideology

This section considers the extent social workers and DVA organisations can effectively support victims in a time of austerity and social funding cuts, and how this is impacted by neoliberal ideology. It argues that the impact of all these, disproportionally effect older victims and the services that seek to support them.

Since 2010 a political mandate was introduced which supports austerity and comprehensive cuts to the welfare system (Chisnell and Kelly, 2019). The impact of various reforms and spending cuts is well documented, but Roy (2019) argues that adult social care has undoubtedly seen the most setbacks. Spending on adult social care in England has fallen by 2% in real terms since 2009/2010 (Institute for

Government, 2019). As developed below this has led to some LAs implementing various cost savings measures. Spending on other services has decreased by a third and more than 75% of England's LAs have cut their spending on DV refuges by nearly a quarter (24%) between 2010 and 2017 (Eichler, 2019; Grierson, 2018).

Austerity is reinforced by neoliberal ideology which effectively questions the idea of the welfare state, proposing that it undermines the economy and the incentive to create wealth (Schram, 2018). Consequently, it ranks economics and financial gain over matters of social justice, and prioritises the individual over the collective (Ornellas, 2020). In line with this, the 'opening up' of public services to privatisation has become common place (Ishkanian, 2014). Additionally, public sector and social welfare reform representing neoliberal ideology has been part of the landscape in many countries, including the UK over the past there decades (Spolander et al, 2014). Although neoliberal policies have been linked to growing inequality (Ornellas, 2020), Spolander and colleagues (2014) argue that this economic doctrine still influences governments economic policy, their commitment to social welfare, human and social rights, and social workers role in promoting, protecting, and enforcing them.

Despite massive budget cuts from central governments, LAs are still expected to retain their duties and meet need (Chisnell and Kelly, 2019). Robbins (2015) argues that the cuts have forced a hierarchy of risk in statutory services, whereby resources are focused on 'high risk' cases. Consequently, lower-level harms such as intimidation and bullying are unlikely to meet thresholds for social services. Even when an older victim meets the threshold required for safeguarding, and their experiences are recognised as requiring specialist support from DVA organisations and/or sexual violence organisations, practitioners are frequently in an unenviable position of reduced access to resources whilst facing increased demands (Wydall et al, 2018). For instance, as noted above, council funding for refuges has been significantly decreased since 2010 (Eichler, 2019; Grierson, 2018) which subsequently impacts on availability (Chisnell and Kelly, 2019). Due to a lack of spaces, social workers may face key challenges when trying to gain victims specialist support. Additionally, the scale of cuts in social spending and rationing of resources has led to staff capacity issues which may limit their chances of developing productive working relationships based on trust (Wydall et al, 2018). To save costs, a common practice is to merge

teams (Cooper et al, 2018; Robbins et al, 2016). As opposed to exclusive teams working with adults aged 65 or over, often social workers now work with any adult aged 18 and over with care and support needs, which can also limit their opportunities to develop productive relationships with older victims. This is concerning because the complexity of abuse in the lives of older survivors require considerable opportunities to build trust, and discussions which show them they will be supported (Blood, 2004, Carthy and Bowman, 2019; Lewis and Williams, 2015; SafeLives, 2016; Scott et al, 2004). Further, because of ageism social workers may class working with older people as mundane and not 'real' social work (Hugman, 2000, Willis, 2016). Thus, when working in a team that is for all adults, they might prioritise their time and efforts to working with younger groups, who are seen as productive. The rhetoric of neoliberalism arguably helps reinforce ageism because it promotes productivity, and casts older people as a 'burden' on resources (Ward et al, 2020). In a time of austerity, the strain on resources created by an ever-growing older population has been and continues to be framed as a pressing concern and dominates pollical debates.

As discussed in Chapter 3, qualitative and quantitative research has exposed a range of abuse committed by domiciliary care workers (Equality and Human Right Commission, 2011; Smith, 2017). Bawden (2017) argues that austerity has led to the chronic underfunding of the social care sector. Consequently, there is an emphasis on quantity rather than quality of the support provided. This arguably contributes to abusive situations committed by home care workers. The focus on quantity has also sometimes impacted on the quality of support provided in care homes. Burns et al (2016) findings illustrate how financial cutbacks, in some homes, were so severe that workers did not have the time or resources to protect residents or maintain adequate levels of care.

There is statistical evidence that the number of older people receiving formal care packages has fallen by 7% since 2105/2016 which Bottery (2020) argues is linked to social care services funding cuts. Without care and support many older people are left without support, which could leave them dependent on partners, spouses, or family members. Dependency on others can increase the risk of victimisation and prevent older victims from seeking support (Dow et al, 2019; SafeLives, 2016; Zink et al, 2003). Social workers are put under additional stress and surveillance to meet targets and

save costs (Chisnell and Kelly, 2019). Due to austerity, and neoliberalism, a discourse is propagated around the need to save money, whereby the reduction of care and support packages becomes legitimised. Social workers are told they must cut care packages and are pressured to act in the interests of saving money, as opposed to working for the real needs of their clients, which can cause them to be disingenuous with service users. Stevens (2017) who is a long-term service user highlights the impact of this, saying he will have to *"fight like cat and dog"* (n.p) to save his support package. He also points out that few users have the *"knowledge, experience or weaponry to fight the system and win"* (n.p). This suggests that most individuals lack the power to dispute decisions made by professionals and are therefore likely to be left with reduced support packages or none at all. The recent statistical evidence just noted (Bottery, 2020), supports this contention. Despite an awareness that a failure to meet needs can leave people at risk to many types of abuse (Chisnell and Kelly, 2019), reductions of hours seem common.

Personal responsibly is key in neoliberal ideology, and this concept is embedded in social welfare policy (Chisnell and Kelly, 2019). The focus on personalisation in the CA demonstrates this well (Carey, 2016). While the rhetoric of the personalisation agenda seems progressive, the reality of individuals being able to truly chose and have control in a time of budget cuts and austerity is questionable (Rogowski, 2013). With large cuts to LA funding, the problem of resources hampers any ability to promote transformational change. Although direct payments were created after demand from service users and their families, personal budgets are dictated by professionals (Stevens, 2017). For example, national and local agendas have appeared that limit how a service user can spend their budget. Moreover, Chisnell and Kelly (2019) contend that a focus on personal responsibility promotes the idea that individuals must take more responsibility, while the role and responsibilities of the State are minimised. This is concerning because there is a significant danger that risk will continue to be further decontextualized and individualised, which obscures how issues around social injustice and inequalities increase the risk of violence and/or abuse. In doing so, the root causes of victimisation against older people, especially the growing inequalities in a neoliberal society, are ignored and left without challenge. There is no simple solution of how social workers respond to the challenges raised, but Rogowski (2013) advocates that they must challenge the status quo by adopting critical practice. This

can be achieved by resisting and challenging policies that stereotype, degrade, cause harm, and put people at risk, and provide alternative narratives that seek to empower marginalised groups and their social networks (Duffy, 2017). It also involves highlighting the structural causes that make people vulnerable (Chisnell and Kelly, 2019).

Austerity has an acute impact on women (Bennett, 2015, Eichler, 2019), which may force more abused women to stay with their abuser because they have fewer resources to secure living arrangements (Robbins, 2015). Independent Domestic Violence Advocates have reported that older victims tend to have additional financial concerns which causes issues when trying to empower them (Rogers and Taylor, 2019). As such, it is arguable that the impact of austerity adversely effects older women who are victims of DVA. Further, funding cuts and the opening up of services led to the commissioning of generic services (Ishkanian, 2014) which may be oblivious to age (MGarry et al, 2014) or fail to understand its relevance (Knight and Hester, 2016). Consequently, the needs of older women are unlikely to be met by most current service provisions (Carthy and Taylor, 2018; Scott et al, 2004). I return to this in Chapter 3. Moreover, by 2013, 28% of organisations working with victims reported cutting essential services such as outreach support (O'Hara, 2020). It has been shown that there is a demand for community-based outreach services for older survivors, for various reasons (Blood, 2004). This includes reluctance to go into refuges because older women do not relish the idea of being surrounded by noisy children, health problems, anxiety about isolation, and fear of losing their assets if they left. Arguably therefore, the reduction in outreach services adversely affects older survivors in comparison to younger victims.

Ishkanian (2014) argues that austerity combined with neoliberalism impacts on the independence and ability of DVA organisations to implement progressive policies that aim to improve the status and opportunities of abused women. In terms of practice, there is a move away from considering power and control dynamics to a more managerial approach that focuses on reducing risk. As a result, specialist organisations concentrate their activity on cases designated as high risk (Robbins, 2015). This is more likely to impact on older survivors due to their systematic invisibility (SafeLives, 2016), and potentially leaves many older women without necessary

support (Robbins, 2015). The shift in focus is likely to impact on specialist organisation ability to address the underlying causes of DVA including gender inequality, and public attitudes that condone violence. This is concerning, as critical practice is essential to help resolve the root causes of victimisation (Hall, 2014), including the growing inequality in the neo-liberalised world (Ornellas et al, 2020). For older women victims, the absence or reduction in critical practice is even more grave, as their experiences are impacted by a convergence of gender and age-related factors (Neremberg, 2002). It is essential to challenge both inequalities as both can increase the risk of violence and/or abuse and act against its resolution (Penhale, 2003).

2.5 Chapter summary

This chapter examined how violence and/or abuse against older people has been framed and understood. Various sources were reviewed to demonstrate that EA is a multifaceted issue heavily dependent on societal understandings (Hall, 2014). I emphasised the importance of recognising the marginalised position of older people and how this is inexorably liked to the concept of vulnerability. The negative impact of these constructions was highlighted by showcasing how older people are perceived as inherently vulnerable and thus less likely to be empowered (Blood, 2004; Lonbay, 2018; Savelives, 2016a), or given the option of pursing prosecution (Clarke et al, 2016). Moreover, ageist stereotypes can hamper some practitioners from asking older women if they are experiencing DA (Blood, 2004; SafeLives, 2016), and because there is assumption it does not occur past a certain age, there is often a failure to recognise DVA against them (Albiston, 2013; Bows and Westmarland, 2017; Lazenbatt et al, 2013; 2014; SafeLives, 2016; Scott et al, 2004; Southend Safeguarding Adults Board, 2011). Additionally, ageist notions produce, sustain, and even condone abuse against older people (Biggs and Kingston, 1995; HAIa; HAIb, 2017; Penhale and Parker, 1999). Due to sexism, this acutely affects women (Walker, 1986). The stereotypes and social dictums anchored in ageist and sexist dictums can cause older women to remain in abusive relationships (SafeLives, 2016; Vinton, 1999).

This chapter argued that the stigma attached to age and vulnerability is reinforced and sustained by Government policy, and the term EA. Both cast older abused adults as inherently impaired and vulnerable, who experience a distinct type of abuse. By highlighting the key similarities and differences between DVA organisation and social

services this chapter has facilitated understanding the connection between DVA and EA. It also helps construct some of necessary footing to analysis my findings. I demonstrate that the remit of safeguarding is wider than DVA, and claimed that the adult protection framework, the term EA, and cultural understandings of abuse reinforce the idea that victimisation against adults is different. This alongside ageist attitudes, is problematic in the context of DVA because older women are supported via the safeguarding route and not by specialist DVA and/or sexual violence organisations (Scott et al, 2004; Wydall, 2015). This is concerning because social services are not necessarily resourced or equipped to deal with DVA (Clarke et al, 2012, McLaughlin, 2018; Robbins et al, 2016; Wydall et al, 2015). Further, issues around a lack of training for both services were highlighted, which impacts on professionals' ability to effectively recognise and respond to older victims (Bows, 2017a; Carthy and Bowman, 2019; Shiel, 2016; Yechezkel and Ayalon, 2013). Next, the differences in how DVA organisations and social services approach risk assessment was discussed, and evidence suggesting social workers either avoid, or do not use DASH was provided (Clarke et al, 2012; Wydall et al, 2016). The grave concerns this raises, due to the risk of fatalities is emphasised (Sharp-Jeffs and Kelly, 2016). Limited research showing the types of interventions initiated was then examined. I show how DVA organisations often deliver interventions themselves, but due to the conceptualisation of DVA and EA, their specific needs are unlikely to be met (Blood, 2004, Carthy and Taylor, 2018; McGarry et al, 2014, SafeLives, 2016, Scott et al, 2004; Shiel, 2016). In contrast, social services do not deliver interventions and are tasked with finding appropriate support (Chisnell and Kelly, 2019). Literature suggesting, they fail to involve older people in safeguarding enquires was presented (Lonbay, 2018). Further, I maintained that as opposed to working with specialist agencies (Bows 2017b) or pursing criminal justice (Clarke et al, 2016), social workers often manage cases through social care interventions. This can leave survivors in dangerous environments with little or no support (Robbins et al, 2016; SafeLives, 2016), which can be lethal (Sharp-Jeffs and Kelly, 2016).

Lastly this chapter draws stark attention to the impact of austerity and social funding cuts, and how this is affected by neoliberal ideology. In the face of restricted budgets, and in line with neoliberal thinking, both DVA services and social services have moved towards managing risk, as opposed to meeting need (Robbins, 2015). This potentially

places people at risk to different types of DVA and/or NDA (Chisnell and Kelly, 2019), and/or potentially leaves DVA victims with no specialist support (Robbins, 2015). The lack of available services further contributes to restricting access to high-risk cases. This risk-based approach particularly disadvantages older victims. Further, I contend that the impacts of funding cuts, combined with the rhetoric of neoliberalism can lead to abuse committed by domiciliary care workers (Bawden, 2017; Equality and Human Right Commission, 2011; Smith, 2017), and showed that financial cuts have led to inadequate treatment and poor care standards in some care homes (Burns et al, 2016). Finally, I highlighted how the focus on risk, by both services prevents professionals from engaging in critical practice (Chinell and Kelly, 2019; Ishkanian, 2014; Rogowski, 2013). Without such practice, issues around social injustice and inequalities, which increase the risk of violence and/or abuse, are left unchallenged. This significantly impacts on older abused women.

Chapter 3: Violence and/or abuse against older people

3.1: Introduction

There is a recognised absence of studies examining violence and/or abuse against older people (Bows, 2019a). However, there is a small pool of emerging research. The purpose of this chapter is to examine literature that explores the prevalence and nature of violence and/or abuse against older people, the impacts on them, barriers to disclosure, and their support needs.

While there has been an increase in attention towards examining victimisation against older people, there has been a lack of consistency to the approach (Bows, 2019a). Research derives from several fields, including, but not limited to, elder abuse (EA), nursing, criminology, social work, and public health (Allcock, 2018). Although there are overlaps, each discipline has its own concepts and theoretical outlook which influence the methodology, definitions, terms, and analysis of results (Bows, 2019a). Studies use various terms, including EA, domestic violence (DV), domestic abuse (DA), interpersonal violence (IPV), and intimate partner abuse (IPA), which are not always defined in the same way, if at all. There are also variations in method and methodology (De Donder et al, 2011). Due to the differences, there is no easily identifiable body of literature (Bows, 2017a). Thus, this chapter adopts an inter-disciplinary approach that straddles somewhat rather traditional boundaries. It draws on literature from the EA, gerontology, criminological, nursing, social work, family violence, and public health fields. Studies in these fields which explore EA, DV, DA, IPV, IPA or mistreatment against older people are considered. While the focus is on the UK, studies from other countries are included as this helps build a fuller picture. Gaps in knowledge and limitations are also outlined, and a brief conclusion is given.

3.2 Prevalence

As a result of various nuances such as differences in methodology, prevalence rates vary (Bows, 2017a; Bows, 2019a; Penhale, 2008). Studies employ various definitions and examine different types of violence and or/abuse against older groups. Certain experiences are sometimes ignored, with Bows (2017a) arguing that this is more acute for experiences of sexual violence. Additionally, there are different sampling strategies

and research designs (De Donder et al, 2011), as well as variations in time frames such as, the previous 12 months, or since a certain age. Further, as detailed in Chapter 1, there is no fixed age which defines ‘older’. Die to all the varitions, it is acknowledged that, within the UK, there is no widely accepted prevalence data for older DA victims (SafeLives, 2016). When abuse occurs in institutions, even less is known about its prevalence (Yon et al, 2018). While it is impossible to gain accurate figures, some indication of its prevalence can be gleamed from various sources. The purpose of this section it to bring together studies and official statistics that indicate the extent of abuse and/or violence against older people.

3.2.1: UK research

O’Keeffe and colleagues (2007) conducted the first national prevalence study in the UK. They surveyed over 2,100 people aged 66 and over, and in private households. Sheltered accommodation was included but care homes were excluded. Throughout their report the term mistreatment was used to denote both abuse and neglect. Five types of mistreatment were examined, physical, psychological, sexual, financial and neglect. The report focused on mistreatment by individuals in a relationship with the older person where there is an expectation of trust, namely family, friends, and care workers. 2.6% said they had experienced mistreatment during 2006, which equates to approximately 227,000. The most predominant type of mistreatment was neglect at 1.1%. This conflicts with research undertaken in Ireland, which indicates financial abuse is the most prevalent type (Naughton et al, 2010). In this study, 2,021 people aged 65 and over living in the community, including sheltered accommodation were interviewed. Like O’Keeffe and colleagues (2007), five types were examined which employ broadly similar definitions, and perpetrators were restricted to those in a position of trust. Naughton and colleagues (2010), and O’Keeffe and colleagues (2007) both found that sexual abuse/mistreatment was the least reported. They also reveal a similar overall prevalence rate. The similarities and differences between the studies is shown in Table 1.

Table 1: Similarities and differences between O'Keeffe et al (2007) and Naughton et al (2010).

Type	O'Keeffe et al (2007)	Naughton et al (2010)
Neglect	1.1 % (highest)	0.3%
Financial	0.7%	1.3 % (highest)
Psychological	0.4%	1.2 %
Physical	0.4%	0.5 %
Sexual	0.2% (lowest)	0.05 % (lowest)
Overall prevalence rate	2.6%	2.2%

3.2.2: International research

Some European countries have a rich history of prevalence studies, while others have just started looking at this (De Donder et al, 2011). Considering studies that include several EU States is therefore beneficial. Three studies examining EA, across EU States all found emotional/psychological abuse to be the most common type, across the countries examined (De Donder et al, 2011; Luoma et al, 2011; Soares et al, 2010). In contrast, studies in the USA using nationally representative sampling found verbal abuse to be the highest (Laumann et al, 2008), or financial abuse by a family member (Acierno et al, 2010). However, another USA study, not using nationally representative sampling, found verbal or psychological abuse to be most prevalent (Brownell et al, 2000). Similarly, research carried out in India found chronic verbal abuse to be the most common type (Chokkanathan and Lee, 2005), and in a developing area of Bolivia psychological abuse was identified as most prevalent (Carmona- Torress et al, 2015). The contrast and similarities between the various studies makes it difficult to identify prevalence rates.

3.2.3: Extent in institutions

Although research examining victimisation against older groups tends to exclude institutional settings, it has been recognised that it is likely to be rife (Krug et al, 2002; Yon et al, 2018) in nursing and residential facilities. When studies are conducted, different methods, sampling strategies and definitions are used (McDonald et al, 2011). Consequently, obtaining precise prevalence data is impossible. However, Yon

and colleagues (2018) offered some insight through conducting a systematic review and meta-analysis of EA in institutional settings. This allows for comparisons with their earlier research in community settings (Yon et al, 2017). Estimates of EA were calculated from studies meeting the inclusion criteria. For institutional settings, nine studies in six countries (Czech Republic; Israel; Slovenia; USA; Germany; Ireland) were identified as suitable. Findings indicate that the overall prevalence rate is higher in institutions and each type also occurs more frequently (see Table 2).

Table 2: Systematic reviews and meta-analysis by Yon et al (2017, 2018).

	Community settings	**Institutional settings**	
Types of abuse	Reported by older adults	Reported by older adults and their proxies	Reported by staff
Overall prevalence	15.7%	Not enough data (NED)	64.2% or 2 in 3 staff
Psychological	11.6%	33.4%	32.5%
Physical	2.6%	14.1%	9.3%
Financial	6.8%	13.8%	NED
Neglect	4.2%	11.6%	12.0%
Sexual	0.9%	1.9%	0.7%

In the UK, there is an absence of research. Although Pritchard (2000) included care homes, figures on the extent of abuse in this setting were not provided. Bows and Westmarland (2017) help fill this gap. Examining rape and serious sexual assault, their findings indicate that sexual violence is most likely to take place within the victim's home and that care homes, hospitals or nursing homes are the second most common location. The difference between their findings and Yon and colleagues (2018) may be attributed to the methodological approach. Bows and Westmarland (2017) enquiry was restricted to incidents reported and recorded by the police, whereas Yon and colleagues (2017; 2018) review was not. In another study, examining five care homes in the West Midlands, different types of abuse were found (Moore, 2017). Psychological abuse was the most common type witnessed (47.6%), followed by

neglect (31.9%) and physical abuse (20.0%). Sexual abuse is not mentioned but it is unclear if this is because it was excluded or not reported. Nevertheless, similarly to Yon and colleagues (2018) findings, psychological abuse was the most common, which thus suggests it frequently occurs in care homes in various countries.

3.2.4 Official statistics

Official safeguarding sources offer some data indicating prevalence. The Safeguarding Adults Collection (SAC) provides information on 'adults at risk', for whom safeguarding concerns or enquiries are opened during a given period, by local authorities (LAs), in England. SAC data indicates that the most common risk location is people's home, followed by institutions (NHS Digital, 2018, 2019, 2020, 2021). The highest number of enquires has consistently been for neglect and acts of omission (NHS Digital, 2018, 2019, 2020, 2021). There also continues to be a higher proportion of females, 74, 970 compared to 53,745 men (NHS Digital, 2020), and 71,010 compared to 51,235 (NHS Digital, 2021). While all the previous figures represent those aged 18 and over, older people are more likely to be subjected to a safeguarding enquiry, with the breakdown by age showing a similar picture for four years as shown in Table 3 below. (NHS Digital, 2018, 2019, 2020, 2021).

Table 3: Number of adults, per 100, 000, involved in enquires, by age brackets, 2018 – 2021.

April 1st – 31st March	**18-64**	**65-74**	**75-84**	**85 and above**
2017- 18	125	258	785	2,462
2018 - 19	116	240	744	2,302
2019 - 20	141	287	847	2,635
2020 - 21	142	279	761	2,304

Enquires are more likely to involve older people, and as individuals age, so do the level of enquires. Age also intersects with health conditions, such as a sensory impairment that results in a need for support (Clements, 2017). However, as younger groups represented in SAC data also have care and support needs, it seems age is a contributing factor leading to people experiencing abuse.

Safeguarding data includes types of abuse which are not covered by the Crime Survey for England and Wales (CSEW), such as neglect, acts of omissions, and victimisation in institutions. However, there are limitations. It does not cover older victims who do not have eligible care and support needs (Clements, 2017). Moreover, despite demands for more detail, there is no breakdown by age of the types of abuse (Action on Elder Abuse [AoEA], 2017). It is therefore impossible to distinguish what types of abuse older people are experiencing, including DVA. Further, four of the risk types (modern slavery, self-neglect, sexual exploitation, and DA) were submitted on a voluntary basis prior to 2017-18 (NHS Digital, 2018). Less than two-thirds of LAs submitted data for these risks in 2016-17, and thus many enquires have not been officially counted. Looking at CSEW figures can help bridge some of these gaps.

Since April 2017, the CSEW provides some indication of the extent of DA, for those ageing from 59 to 74. It also still presents data on younger groups. DA measured by the CSEW combines non-sexual abuse, sexual assault, and stalking carried out by a partner (including former) and or a family member.[1] In the year ending March 2020, women aged 16 to 19 were significantly more likely to be victims of any DA. Women in the 60- to 74-year-old age bracket were the least at risk_(ONS, 2020b).[2] In 2019, DA was most prolific in the 20-24 age bracket and decreased quite substantially with older age (ONS, 2019a). Percentages for all types of DA in 2020 and 2019 are not disaggregated by age and it is therefore impossible to ascertain which categories of DA older people experience. However, in the previous year there was a breakdown of type by age. In the year ending March 2018, for those aged 60 to 74, the most frequent type measured was nonsexual, by a partner or family member (2.2%), with

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[1] The definition broadly matches the Government definition of DA, see chapter 1 for definition.
[2] The face-to-face CSEW was suspended on 17 March 2020 due to coronavirus pandemic, and the telephone operated CSEW excluded questions on DA. Consequently, the DA estimates are not available for the year ending March 2021 (ONS, 2021b).

emotional and financial amounting to the highest in this category (1.1%), threats (0.8 %), and force (0.6%) (ONS, 2018b).

The CSEW is beneficial as it potentially reveals victimisation not captured by SAC because there is no requirement for participants to have eligible care and support needs. It can also include unreported crimes and is not impacted by changes in police recording practices (ONS, 2019b). However, there are several limitations, as it excludes people aged over 74. Given SAC data indicates those aged 85 and above, are more likely to experience abuse, reservations about this restriction are valid. This limitation contributes to the invisibility of DA of this age group. When official figures do not include older people, it can impact on how resources and funding are allocated, and thus older people who need specialist services, such as DVA and rape crisis services, could be left in abusive situations (Age UK, 2020). Furthermore, care homes and other institutions are excluded, and it does not capture victimisation committed by strangers, acquittances, peers, or care providers. These restrictions contribute to the invisibility of many older victims (Hall, 2014).

Police recorded data fails to provide data on the extent of DA for specific age groups (ONS, 2021a). Nonetheless, research suggests that although DA incidents are infrequently reported to the police, this is particularly true for older women (Acierno et al, 2001). Police recorded data does however provide some indication of the prevalence of violent crimes. This broad term covers a variety of offences, including minor assaults, psychological abuse, physical assault, and wounding (ONS, 2019b). Information taken from 24 forces in the year ending March 2020 shows that younger adults are more likely to be victims of violent crimes (ONS, 2021). Likewise, the CSEW estimates that adults aged 16-24 are most likely to be victims of violence in comparison to older age groups (ONS, 2021a).

3.2.5: Section summary

International research indicates that psychological/emotional abuse/mistreatment is the most prevalent type. To some extent official UK statistics support this, as it shows emotional DA is one of the most frequent types experienced by people aged 60 to 74 (ONS, 2018b). In contrast, UK research (O'Keeffe et al, 2007) and SAC data (NHS Digital, 2018, 2019, 2020, 2021) suggests that neglect and acts of omission are most

prevalent. However, SAC data includes younger adult victims. As there is no breakdown by age, it impossible to ascertain what percentage apply to older groups, but as more enquires involve older people, it can be inferred this relates mainly to people who are older. Many studies exclude institution settings, but combined data analysis from five countries suggests EA occurs more in these settings (Yon et al, 2017, 2018). UK research including institutions, examining sexual violence suggests that this type occurs more frequently in the home. Both the CSEW and police recorded data infer older people are less likely to be victims of violent crimes (ONS, 2021), and the CSEW shows younger groups are more likely to experience DA (ONS, 2019a, 2020b).

3.3: Nature of violence and/or abuse in the community

This section explores what is known about the nature of violence and abuse within the community. It includes considering types of violence and/or abuse, the nature and characteristics of violence and/or abuse against older people from minority groups, and the victim- offender relationship.

3.3.1: Types of violence and/or abuse

UK research consistently indicates that older women are more at risk of violence and/or abuse than men (Bows and Westmarland, 2017; O'Keeffe et al, 2007; Naughton et al, 2010). Nevertheless, when looking at specific types of violence and/or abuse, sometimes the gender divide is less pronounced. O'Keeffe and colleagues (2007) found that prevalence for financial abuse was similar for both sexes, when measuring data *'in the last 12 months'* (0.5% for men, 0.7% for women), and only 3% higher for women *'since the age of 65'*. However, they also found that women were substantially more likely to report interpersonal mistreatment than men (1.6% compared to 0.1 %), and for psychological abuse, women were also disproportionately affected (0.8% compared to 0.0%). In contrast, EU research has found more men to be victims of psychological and financial abuse than women (Soares et al, 2010). Similar, to O'Keeffe and colleagues (2007), Naughton and colleagues (2010) reveal women are more likely to experience intrapersonal abuse, but had a higher chance of experiencing financial abuse. While these studies help shed some light on the prevalence of different types of abuse, they fail to describe victims' experiences. To some extent Mowlam et al (2007) remedies this in relation to abuse committed by

partners or spouses. Mowlam et al (2007) summarise how older survivors described living with constant criticism and being undermined. While this arguably carries some features of coercive control, there is no recognition of this in their analysis.

Evan Stark (2007) coined the term coercive control and highlighted how abuse is an ongoing pattern of behaviour that seeks to take away the victim's liberty or freedom, and strip away their sense of self. It is entrenched in sexual inequalities and the reinforcement of unequal gender and sex roles and is used by men to entrap women in everyday life (Stark 2007, and 2009). While physical and fatal violence can be features, physical violence is not always present (Buzawa et al, 2017). It can include a wide variety of coercive tactics including mind games, degradation, isolation, and the micro-regulation of everyday life (Buzawa et al, 2017). Although this concept is 'ageless', literature examining coercive control has primarily focused on young couples.

A USA study by Policastro and Finn (2015), recognising this gap, explored the effects of two components of coercive control perpetrated by intimate partners (emotional and financial), on the risk of physical abuse at age 60 and older. Findings indicate that older adults who experienced emotional coercive control by their intimate partners in their lifetime were more likely to experience physical abuse at age 60 or older. It was concluded that the concept of coercive control is relevant in understanding an increased risk of physical violence in later life. While this helped cast some light on coercive control against older adults, it did not reveal a broader range of controlling actions, such as surveillance and intimidating behaviour. Moving beyond this limitation, in a later study, Policastro and Finn (2017) investigated the effects of sex on two forms of coercive control, intimidation, and surveillance, and how age impacts on these. Respondents were asked 13 questions in relation to coercive control and entrapment tactics used by their romantic or sexual partners(s) in the past year. Five items were used to create a measure for surveillance. These items were: partner(s) trying to keep the respondent from seeing or talking to their friends/family; making decisions for them that should have been theirs to make; keeping track of them by demanding to know where they were and what they were doing; kept them from leaving the house when the wanted to go; and keeping them from having money for their own use. Respondents were then asked to indicate if their intimate partner(s) had

engaged in any of these items. To capture intimidation, seven items were used as a measurement which were: threatening to hurt themselves or commit suicide when they were upset with respondents; threatening to hurt a pet or threatening to take a pet away from them; threatening to hurt someone they love; hurting someone they love; destroying something that was important to them; saying things like "if I can't have you, then no one can"; and making threats to physically harm them. It was found that regardless of sex, older people were less likely to experience surveillance (13.7% compared to 4.3%) and intimidation (7.8 % compared to 1.5%), than younger groups. Despite some evidence that adult children are the main perpetrator of EA where control tactics might be present (Frazoe et al, 2014; Naughton et al, 2010), research exploring coercive control focuses on heterosexual partners in intimate relationships (Sprangler and Brandel, 2007). Consequently, very little is known about how coercive control features in abusive situations when family members are the perpetrators (Wydall and Zerk, 2017).

3.3.2: Minority groups

Little is known about the nature and characteristics of abuse against older people from minority groups. However, older victims from marginalised groups can be subjected to a range of victimisation. For instance, Duffy (2017) highlights how many older Lesbian, Gay, Bisexual, Transgender (LBGT) people experience horrific treatment by various institutions, and society as a whole. This discrimination and abuse is due to their sexuality and/or gender. These factors can act as barriers to disclosure and cause a reluctance to engage with services. While studies are rare, USA research on older lesbians, found participants were less likely to experience homophobic victimisation compared to their younger counterparts, but more prone to report theft (Stacey et al, 2018). There is little knowledge about the experiences of abuse of people identifying as transgender (Donovan and Barnes, 2017), and even less is known about how this is impacted by age (Westwood, 2018). Older and younger migrant women and those in the travelling community are also generally excluded from research (Harne and Radford, 2008). When inequalities intersect, the nature and characteristic of abuse against older people is even further obscured, such as the interconnection between older victimisation and LGBT, black and minority survivors (Woody, 2014).

Examining various marginalised groups, a Canadian study used focus groups to explore the perceptions of EA among Aboriginal peoples, immigrants, refugees, and lesbians (Ploeg et al, 2013). Similarities were found across the groups. For instance, sexual abuse was rarely mentioned in any depth and often only after prompting by the facilitator. Participants frequently discussed examples of systematic abuse, such as financial abuse by the Government who provided pensions too small to cover reasonable expenses and underfunded long term care facilities, resulting in various forms of abuse. Perceptions also varied, for example, female refugees from Afghanistan and Iran focused almost exclusively on the continuation of culturally sanctioned spousal abuse into older age, members of the Latvian focus group (men and women) concentrated considerably on emotional abuse, and aboriginal women and men mainly discussed financial abuse.

Older people from Black, Asian and minority ethnic (BAME) backgrounds are diverse and the impacts of migration, language, culture, age cohort, socio-economic status, and social networks can create differences in experiences of victimisation (Manthorpe and Bowes, 2010). Despite these nuances, relatively little attention has been paid to abuse against older people in BAME communities. Although studies are scarce, Bowes and colleagues (2012) examined understandings and experiences of mistreatment of older BAME people in Scotland. Five participants (9%) disclosed experiencing mistreatment themselves, reporting physical and psychological abuse. The most common form of mistreatment identified was a lack of respect (74%). There were also differences. For example, White Europeans and South Asians did not discuss sexual abuse at all, while Muslims were more likely to talk about mistreatment in public places such as the street.

Research examining violence and abuse against disabled people is scant, and they are significantly underrepresented in DA services (SafeLives, 2017). At any age, disability can increase the likelihood of experiencing DA, and perpetrators can use intensified methods of coercive control such as the threat of institutionalisation. Disabled DA victims also suffer more severe and frequent abuse over longer periods of time than non-disabled people. Casting light on older people with moderate or severe disabilities, a retrospective analysis of alleged DV cases between 2005 and 2013 in Porto found the most frequent type of abuse was physical (86%), committed by men (63%), who lived with their victims (90%), and were commonly their children

(47%) or partners (49%) (Frazao et al, 2014). Females were the main victims (63%) who in 49% of cases had motor disabilities; 9% sensorial; 7.1% mental and 21% had multiple disabilities.

3.3.3: *Victim-offender relationship*

Three main categories of relationships identified in the literature, these are: someone the victim knows (usually a partner, ex-partner, family member, friend, or care worker), an acquaintance, or a stranger. Studies in the UK have found that perpetrators are usually known to the victim. O'Keeffe and colleagues (2007) show that spouses/partners were found to be the most frequent perpetrators of mistreatment in the past year than other family members, care workers, or close friends. The type of mistreatment varied with type of perpetrator. Neglect was mainly committed by partners (70%), and other family members (58%). Likewise, partners (57%) and other family members (54%) were also the main instigators of interpersonal abuse. Naughton et al (2010) show the prevalence of EA in the previous 12 months is found to be mainly committed by adult children, followed by other relatives, then spouses or partners, then friends. Interpersonal abuse tended to be more common for a spouse/partner perpetrator, while adult children were equally as likely to commit both financial abuse (47%) and interpersonal abuse (50%). As noted, the study carried out in Porto also found perpetrators were commonly children (Frazoe et al, 2014). While both the UK studies found that perpetrators are usually known to the victim, there are differences between the type of relationship and perpetrators, as shown in Table 4.

Table 4: Overall prevalence type by relationship (O'Keeffe et al, 2007 and Naughton et al, 2010).

<table>
<tr><th></th><th>O'Keeffe et al (2007)</th><th>Naughton et al (2010)</th></tr>
<tr><td rowspan="5">Overall mistreatment/ EA in past year by relationship type</td><td>Spouse/partner 51 %</td><td>Spouse/partner 20 %</td></tr>
<tr><td>Other family member 49 %</td><td>Other relatives 24 %</td></tr>
<tr><td>Care worker 13 %</td><td>Home help 2 %</td></tr>
<tr><td>Close friend 5 %</td><td>Friend 4 %</td></tr>
<tr><td></td><td>Adult children (50 %)</td></tr>
</table>

Research from the USA has also found that most perpetrators are known to victims, and more likely to be partners or spouses (Acierno, et al, 2010). Similarly, a USA study examining elder victimisation committed by caregivers, for LBGT individuals, revealed 53.0% was perpetrated by (same sex) partners (Grossman et al, 2014). Within the UK, abuse by same-sex partners have been highlighted when examining abuse against LGBT individuals, but also includes neighbours (Westwood, 2018). It seems therefore, that the most frequent relationship dynamic is usually spouses and partners.

Although some studies include wider perpetrators within the scope of 'someone the victim knows', most research in the UK that listens to the voices of older women is restricted to heterosexual partners/spouses who have experienced DV or DA (Lazenbatt et al 2013, 2014; Mc Garry 2010, 2011; Pritchard, 2000; Scott et al, 2004). When wider perpetrators are included (Mowlam et al, 2007; Naughton et al, 2010), there is a failure to examine the possible differences in their experiences. This dearth is particularly concerning in relation to adult children because UK quantitative research indicates that older people are almost as likely to be killed by their adult child (44%) as they are by their partner (46%) (Bows, 2018). There is a significant shortage of qualitative research exploring child to parent violence (CTP) (Simmons and Baxter, 2018). Even less is known about adult children to parent violence (ACTP) because research and academic debates mainly focus on adolescents, and occasionally younger children (Bonnick, 2020; Holt and Lewis, 2021; Simmons and Baxter, 2018; Wilcox, 2012). Holt (2017) suggests there are significant differences between adolescents and adult children when considering pathways into killing. Rogers and Story (2019) further highlight how an awareness of the contextual background helps identification of risk factors and facilitates prevention. Nevertheless, as explored in section 3.3.5, an understanding of the nature of ACTP is limited (Holt and Shon, 2018).

Abuse can be committed by domiciliary care workers (Smith, 2017). While there is evidence that this happens, media reports are far and few between, leading to the impression that this type of abuse is rare (Smith, 2014). While studies are rare, there are exceptions. The Equality and Human Right Commission (2011) conducted 40 face-to-face interviews with older people using home care. Their stories provide rich data highlighting their experiences of a range of abuse. This included physical abuse, theft, neglect, and issues around privacy and dignity. Further, a UK quantitative study found that most claims against domiciliary care workers were in relation to those aged

80 and over, and mostly related to neglect, followed by physical abuse, then psychological abuse, and lastly allegations of sexual abuse (Smith, 2017).

Except for some studies (Naughton et al, 2010; Ockleford et al, 2003), which have contrasting results, acquaintances and strangers are often excluded. Naughton and colleagues (2010) found that the inclusion of strangers increased prevalence rate from 2.2 % to 3%, while Ockleford and colleagues (2003) indicate that neighbours and strangers are the most frequent perpetrators of either threatening behaviour or abusive behaviour. Notwithstanding this, Naughton and colleagues (2010) included sexual mistreatment, but Ockleford and colleagues (2003) excluded any type of sexual victimisation. It is therefore meritorious to consider studies that have examined sexual violence. Inconsistent findings are seen, for example some note high levels of rapes committed by strangers (Burgess, 2006; Burgess et al, 2007; Jeary, 2005), whereas others show perpetrators are usually known to the victim (Pinto et al 2014).

3.3.4: Nature of abuse by adult children

Research examining the nature of ACTP is somewhat limited (Holt and Shon, 2018). However, a few studies, across various jurisdictions have focused on aggression and violence against family caregivers, including parents (Band -Winterstein and Avieli, 2017; Band -Winterstein et al, 2014 and 2016; Binder and McNeil, 1996; Kropt and Kelly, 1995; Lefley, 1987; Solomon et al, 2005; Vaddadi et al, 2002). Nevertheless, because they are limited to adults with psychiatric disorders and disabilities, they are not representative of abusive adult children without disabilities and severe mental illnesses. Moving beyond conceptualisations which focus on individualistic dysfunctions and its connection to abuse, there are other studies from various jurisdictions that help cast light on the nature of ACTP.

Findings from Ireland indicate adult children are the main perpetrator and highlight that unemployment (50%) and addiction (20%) were characteristics of these perpetrators (Naughton et al, 2010). They were equally as likely to commit finical abuse (47%), as they were intrapersonal abuse (50%). Nonetheless, voices of older victims are absent and thus the findings lack a richer description which can gain a better representation of authentic, real life, lived experiences (Pierre and Roulston, 2006). Taking this qualitative approach, another study reports one experience of threatening behaviour from stepchildren, two respondents described estrangement from their children, and

some respondents detailed experiences of physical and sexual abuse committed by foster children (Mowlam and colleagues, 2007). However, the age of perpetrators is not given, so it is unclear if these situations were committed by adolescent or adult children. In a similar vein, one study which was carried out in Sydney, examined the types of abuse by adolescent and adult children reported by 60 women, aged between 40 and 65 (Stewart et al, 2007). The analysis identified four categories of 'acting-out' abuse (physical, verbal, domineering and obstructive) and three categories of psychological abuse (manipulative, severing relationships and betrayal of trust). Acting out' was a common report by women aged 60 and over. This type of abuse was summarised for all age ranges as including physical abuse, such as threatening with a knife or gun; destroying property; verbal abuse incorporating yelling, swearing, tantrums and threats; domineering abuse which involved the child asserting or trying to assert power and control over the parent or parents, including standing over her demanding money; and obstructive abuse which was a form of domineering behaviour aimed at preventing the mother from achieving goals of her own, such as going out for her own benefit. Subsequent quotes and analysis follow this but there is a failure to identify which age range the quotes relate to and as such, it is impossible to identify if they are the voices of older women. The cultural expectations of children and parenting are ever changing, and subsequently impact on how parents perceive and respond to their children's behaviour (Crossley, 2018; Lansford, 2022). Given Stewart and colleagues (2007) study includes the experiences of mothers in three different periods (the Depression, wartime, and the baby boom years), it is disappointing that comparisons do not meticulously tease out the potential differences in their experiences.

While the previous studies do not distinguish the differences in experiences of different ages of victims and/or perpetrators, a study carried out in Israel solely focuses on ACTP against older parents (Band-Winerstein, 2015). The researcher uses a phenomenological methodology to focus on the subjective experiences of family members involved in violent, abusive, and neglectful relationships. They found that family dynamics brought about a range of abusive situations including physical violence, verbal aggression, financial exploitation, and forms of neglect. While this helps build a picture of ACTP, due to the methodology and subsequent gender-neutral analysis, it is not clear how women's experiences were affected by the social

construction of motherhood and other gendered considerations. Moving beyond this to some extent, Smith (2015) and Smith (2020) drew attention to the strains that emerged when older mothers shared their home with their adult child. This included violating maternal expectations by not living up to their potential or failing to treat them with respect. Her analysis of the findings show how older mothers are impacted by maternal identity and ambivalence, and the 'internalized mandate' to be a good mother despite their older ages. Despite focusing on older women only, the study did not employ a gendered lens, which is, as argued in Chapter 4 beneficial because it promotes an understanding of abuse that has societal causes. Until a wider context is acknowledged, any responses to abuse will ignore the root causes and continue to perpetuate abuse.

Filling the gendered methodological gap, an unpublished study carried out in the UK examined ACTP (Nguyen Phan, 2021). An intersectional feminist framework informed by critical realism was employed to explore the experiences of mothers abused by *"their now adult children"* (pg. 51). Eleven women were interviewed and four of these were over the age of 65. However, Trisha's experiences involved abuse by her son before he was 18 and thus falls into the CTP category, both Grace and Stella had been estranged from their sons for "a long time" (pg. 75) and it is not always clear if reports of their experiences were pre or post 60, but some situations clearly related to when their sons were children, and thus fall into the CTP category. Only, one participant- Lizzy, disclosed how her adult son had *'recently'* (pg. 62) been convicted of a serious assault against her (Nguyen Phan, 2021). Since she was 65 at the time of the interview, this would fall within the ACTP remit against older women. Lizzy also disclosed behaviours that seemed to be controlling and coercive in nature, such as wanting her to himself and not wanting her to laugh (pg. 81); experiences of belittlement such as being called *'pathetic'* (pg. 86); feeling she was *'living on eggshells all that while'* (pg 87); being careful about who she had in the house (pg 88); how her son (Andy) had smashed up her home (pg.100); feeling she was *'locked'* up and how this felt like a *'prison sentence'* (pg.102). Nevertheless, Andy's *"downward spiral of criminal justice involvement and addiction, over the course of which Andy also become a 'nasty boy'"* (pg.62), started when he was 15. Thus, it is evident some of his actions took place in his adolescent years. Thus, except for the experience leading to the recent custodial sentence, it is not clear if the other reported incidents occurred

before or after Andy was 18, or before or after Lizzy was 60. Consequently, this study only offers a glimpse at the nature of ACTP, against one woman over the age of 60.

3.3.5: Section summary

UK research offers some glimpse at types of abuse but is silent when considering how coercive control features within different types. Further, there is little known about the characteristics of abuse against older people from minority groups. Most research in the UK focuses on violence and/or abuse committed by someone the victim knows and usually this is heterosexual partners. Although one UK study included wider perpetrators and groups (Mowlam et al, 2007), it is impossible to identify how survivors' experiences might vary in relation to the type of perpetrator. While Naughton and colleagues (2010) address this to some extent, there is no exploration of victims lived experiences. Further, neither Mowlam and colleagues (2007) or Naughton and colleagues (2010) take a gendered perspective when analysing their findings.

Another gap in the literature relates to the exclusion of wider groups, such as LBGT, BAME, immigrants, and refugees, and different perpetrators, such as adult children, acquittances, neighbours, and strangers. For adult children, this is to some extent is addressed by unpublished research by Nguyen Phan (2021), but the findings only conclusively cast light on one experience of ACTP against a woman who was aged over 60 when the abuse took place. Restrictions limit our understanding of the differing patterns and dynamics of violence and/or abuse against older women. Consequently, Meyer and colleagues (2020) argue that further studies are needed which include victimisation beyond IPV. This is offered by my research. There is also a pressing need to explore the experiences of minority groups, which my study achieves to some extent.

3.4: Nature of violence and/or abuse in institutions

Institutional abuse refers to forms of abuse occurring in institutional settings (Penhale, 2014). Despite some evidence that it is rife, little is known about how abuse against older people manifests within such settings (Yon et al, 2018). Although Prichard's (2000) study included two women in nursing homes, there is no analysis of their experiences while institutionalised. Notwithstanding this, there is some literature that

helps build a picture of the nature of violence and/or abuse in institutions. The purpose of this section is to examine this and delineate the gaps.

3.4.1: Types of violence and/or abuse

The term institutional abuse is often used to denote physical or psychological harm, as well as violations of rights in any setting where treatment, care, and assistance are provided to dependent older adults (Penhale, 2014). Exploring some forms of institutional abuse, Yon and colleagues (2018) findings indicate that reports of psychological abuse are the most frequent type reported by staff, and older adults and their proxies. As shown in Table 5, reports of other types varied all depending on who reported it. Estimates by older residents themselves were highest for psychological abuse, followed by physical, financial, neglect, and sexual abuse. Nevertheless, research from the USA suggests that physical abuse is the most prevalent type in care settings. Allen and colleagues (2003) analysed 3443 nursing home complaints related to resident care and abuse from 1998 to 2000. Abuse complaints were made against 122 nursing homes and included psychical abuse (n 50), gross neglect (n 23), verbal abuse (n 23), financial exploitation (n 16), and sexual abuse (n 15). Similarly, a study carried out in Sweden found that physical abuse (74%) was the highest reported type (Saveman et al, 1999). In a review of institutional abuse in Italy which included a wide range of studies, research, police inspections, and policy documents, the most common form of reported abuse was found to be neglect, expired medications, and lack of hygienic conditions (Melchiorre et al, 2014). While figures from these studies and reviews provide data on prevalence, they fail to offer any contextual background of the nature of the types.

Table 5: Types of abuse in institutions (Yon et al, 2018).

Types of abuse	Reported by older adults and their proxies	Reported by staff
Overall prevalence	Not enough data (NED)	64.2% or 2 in 3 staff
Psychological	33.4%	32.5%
Physical	14.1%	9.3%

Financial	13.8%	NED
Neglect	11.6%	12.0%
Sexual	1.9%	0.7%

Studies examining the institution setting are mainly quantitative and rely on confined or alleged cases that are brought to the attention of self-professionals (Hawes, 2003). However, a recent study carried out in Sweden, listened to the voices of older victims in a hospital clinic (Ludvigsson et al, 2022). In interviews, participants described five types of abuse: neglect, psychological, economical, physical, and sexual violence. However, patterns of neglect and psychological violence were most prominent in their stories. Neglect occurred in relation to different staff and across a variety of needs. For instance, their hygiene needs were neglected due to limited help with showering, cleaning, and washing services. Insufficient assistance with buying food or medication was attributed to staff shortages. Neglect also occurred for medical needs and could involve incompetent wound dressing or staff forgetting to administer medications. Psychological abuse was often connected to neglect and was often perceived as a means by which to control or manipulate the older participant's behaviour. Physical abuse included being hit by hospital staff and one participant reflected on the fear this caused. In relation to sexual abuse, the story of an 84-year-old woman reveals her feelings of shame and disgust after a healthcare member of staff made sexual invitations to her. Findings from the USA help shed some further light on the types of sexual abuse occurring in nursing homes. Teaster and Roberto (2004) found that the most common form of sexual abuse was sexual kissing, fondling, and unwelcome sexual interest in the women's body. Other studies also show a variety of sexual abuse including anal and vaginal penetration, rape, oral/genital contact, and different kinds of verbal sexual abuse (Teaster et al, 2007; Burgess et al, 2000; Ramsey-Klawsnik, 2008).

A few studies and evidence from safeguarding reviews in the UK also help understand the nature of abuse in institutions. Furness (2006) carried out a small-scale study, in the North of England, in registered private care homes. Managers provided examples of known abuse, which included rough handling, speaking inappropriately or sharply to residents, residents being left on a commode/toilet, physical abuse, theft, force

feeding, lack of choice, lack of respect for dignity and privacy, misuse of medication, a resident sexually harassing another resident, and a male resident hitting his wife who had dementia. Looking at possible misuse of medication, which is categorised as a form of physical abuse (Department of Health (DoH) and Social Care [SC], 2021), Maguire et al (2003) found that 20% of elderly people in care homes in Northern Ireland were administered antipsychotic drugs, compared with just 1% of those living in the community. Further, prescriptions for antipsychotic drugs increased from 8% before entering a care home, to 18.6% afterwards. The researchers concluded that although individuals going into care homes are more likely to require medication, the dramatic increase in prescriptions could not be fully explained. Their findings raised valid questions about the overuse of very powerful antipsychotic drugs in residential settings.

Evidence of the nature of abuse is highlighted by several safeguarding reviews. For example, in 2000, Peter McKenna, who was 60, died 13 days after being transferred to Leas Cross nursing home (O'Neill, 2006). His death sparked an inquiry into other deaths at the home, 95 in total. Among other things, pressure sores were documented in 33 of the 100 available notes, and an alarming number of residents were nursed in Buxton chairs. Furthermore, the serious case review (SCR) into the abuse and neglect of 19 elderly former residents at Orchid View nursing home, found that five of the deaths were a result of 'sub-optimal' care and neglect. Residents were given inaccurate doses of medication, left soiled and unattended due to staff shortages, and call bells were often not answered for long periods or could not be reached by elderly people (West Sussex Safeguarding Board, 2014).

3.4.2: Minority groups

Knowledge on the nature and characteristics of abuse in institutions for minority groups is very limited. Kendall-Rayner (2017) argue that staff in care homes typically assume older people are asexual, or heterosexual, which may lead to discriminatory abuse and/or inadequate support because it is not person-centred. It has also been shown that when health care workers hold negative attuites towards gay or lesbian patients they fail to provide adequate care for them (Matharu et al, 2012). Bowes and colleagues (2011) explored issues of mistreatment in care homes, with a focus on dignity and respect. They found that BAME residents and their families are inhibited

from complaining about poor care due to negative experiences and possible low expectations of care. Racism, misunderstandings about cultural differences, and problematic attitudes negatively affected all those involved. Notwithstanding this, while it is likely older residents were included in this study because the care home resident population for those aged 65 continues to grow (ONS, 2014), the age of respondents is not provided.

Older people residing in care homes are likely to have significant care and support needs (Chisnell and Kelly, 2019). Despite this, studies examining the intersection between disability and victimisation is lacking. Kelly's (2010) research into locked wards for people with dementia casts some light on this by revealing abusive practice and dehumanising treatment in some of these regimes. The age of participants is not given, but as dementia is a key issue for people who are older (Alzheimer's society, 2007), it is feasible some of the respondents are older. Research from beyond the UK helps to fill some gaps. Burgess and colleagues (2000) examined 20 cases of residents involved in civil lawsuits in the USA. 12 victims of sexual abuse in nursing homes had a cognitive impairment or other cognitive/neurological disorders due to dementia, and 15 were confined to a bed or a wheelchair. Most were female (90%), aged 60 and over (85%), and white (80%). Two (10%) were men, both older than 70. It has also been shown that most victims of sexual abuse in nursing homes have cognitive impairments (dementia, Alzheimer's, stroke, and brain injury), psychiatric diagnosis and/or physical frailty (wheelchair, bedridden, paralyzed, and reduced mobility), and somatic illnesses (Teaster, 2004; Teaster et al, 2007; Ramsey-Klawsnik, 2008; Burgess, 2000).

3.4.3: Victim – offender relationship

Within the care setting, the main two types of victim–offender relationship identified seem to be resident to resident, and members of staff, sometimes referred to as unrelated carers. Examining resident to resident abuse, a study conducted in New York found 13 different types of resident-to-resident aggression (RRA) in nursing homes (Pillemar et al, 2012). RRA mainly occurred due to the incursion of personal space, invasion of room privacy, other residents trying to act as caregivers, and problems with roommates. In another study conducted in Australia across 13 aged care facilities, between 01 January and 31 December 2017, a total number of 169

RRA incidents were recorded, representing 0.56 incidents per 1000 beds (Joyce, 2019). In most incidents (89.9%) the aggressor had a cognitive impairment. Most incidents were classed as physical abuse (62.7%), and a punch or strike was the most common form in this category (one in six of all incidents). Following this, verbal abuse was recorded at 20.1%, and last sexual abuse (17.2%). Similarly, in a Norwegian study, physical abuse was most commonly related to RRA (Saga et al, 2021). Conversely, a USA study conducted across 10 States by Nicholas and colleagues (2012), found types of verbal abuse (yelling [97%], insulting remarks [94%], cursing [97%], and humiliating remarks [96%]) were higher than most types of physical abuse (pushing, grabbing, or pinching [94%], pulling hair or kicking [47%], and other physical violence [18%]). Sexual abuse was found to be the lowest.

The inclusion of sexual abuse is often excluded (Bows and Westmarland, 2017; Malmedal et al, 2015), but some studies have focused on this type of victimisation. For instance, Rosen and colleagues (2010) found that fellow residents often commit sexual abuse or display hypersexual behaviour, and Roberto and colleagues (2004, 2005), and Teaster and Roberto (2004) both found that women living in residential settings were usually sexually abused by other residents. In a study carried out in the UK, Bows and Westmarland (2017) conclude that their findings possibly indicate that a significant proportion of rapes in care homes are perpetrated by other residents.

While UK research suggests that a high portion of rapes in care homes are committed by other residents, the highest victim and perpetrator relationship was unrelated carers (25%) (Bows and Westmarland, 2017). There is evidence from the USA that older people in assisted living facilities and nursing homes, are mainly abused by staff members (Phillips and Guo, 2011, Ramsey-Klawsnik, 2008). Likewise, 70% of staff in a survey carried out across 27 nursing homes in Germany admitted they had committed abuse (Goergen, 2004) and 60.3% out of 3693 nursing staff in a Norwegian study reported they had perpetrated one or more incidents of abuse, including psychological and neglect (Botngard et al, 2020). Further, in Sweden, 499 nursing staff from 19 residential settings participated in a survey about their knowledge of EA in these settings (Saveman et al, 1999). 2% reported that they had been abusive. The highest reported incident was admissions of committing physical abuse (71%), next was psychological (71%), and then neglect and maltreatment (56%). In a study carried out in Canada, perceptions of abuse in institutions were explored by listening to the

voice of older residents themselves, or members of the institution on their behalf (Sandra, 2000). Patients told stories of behaviours by nurses which were perceived as abusive including, pinching residents' cheeks, pinching a hand, breaking an arm, skin tears, using derogatory language, use of restraints, leaving residents in pain, and pushing the step stool away so that feet were left dangling.

3.4.4: Section summary

There are significant gaps which limit our understanding about the nature and characteristic of violence and/or abuse against older people in institutions. Knowing there is an issue, but not knowing details causes issues in creating evidence-based polices that provide guidelines for resources and programmes essential to ameliorate abuse (McDonald et al 2011). Creation of suitable interventions in the UK demands gaining knowledge of the issue from all parties involved, including survivors, staff, managers, and possibly others such as family members and therapists (Parker, 2001). To enable this, research exploring the nature and characteristics of violence and/or abuse in institutions is warranted. The current study offers a small glimpse into abuse committed in care homes.

3.5: Risk factors

Something that increases the chances of experiencing victimisation is classed as a risk factor (Pillemer, 2016; White, 2017). The World Health Organization (WHO) (2021b) identified four main groups of risk factors: individual, relationship, community, and socio-cultural level- or any combination of these. With the aim of highlighting various factors that place some older people more at risk than others, this section considers these four groups. However, relationship factors are considered alongside community risk factors.

3.5.1: Individual level risk factors

Certain individual characteristics are considered as placing some older people more at risk than others, including gender (WHO, 2021b). Choi and colleagues (2017) argue that gender inequalities across the life-course often make women more vulnerable to victimisation than men. Older women often suffer multiple disadvantages grounded in traditional gender roles and have less economic resources (Centre for Aging Better

(CFAB), 2019a; 2019b), which places them at increased risk (Choi et al, 2017). Ageing can exacerbate risks women encounter in their life because they often experience lowered status due to loss of work, friends, partners, networks, and limited powers they possibly once held in society (Mirowsky and Ross, 2003). This can leave them susceptible to various forms of abuse (Brozowski and Hall, 2010). Older women are also often poorer. Recent UK statistics reveal that 23% of single female pensioners are living in poverty compared to 18% of single male pensioners (Women's Budget Group [WBG], 2018). This is because family circumstances impact the life-course and employment patterns of women more severely than men. Many women who work undertake most of the care for children and other relatives and are more likely to be in part-time work (CFAB, 2019a). Poverty can intensify experiences of victimisation by increasing or prolonging women's exposure to it and reducing their ability to flee (Women's Aid [WA], 2019). When gender intersects with race and disability, the situation is more acute because women from minority groups and those with disabilities face a higher risk of poverty (WBG, 2018). SafeLives (2016) argue this might be exacerbated for older BAME women, particularly those from a religious background, as there may be additional cultural, family, and personal pressures to remain in an abusive relationship.

Research from America indicates that being less well-off financially increases the risk of EA in residential care settings (Hawes, 2003). Furthermore, most studies consistently find that being female is a significant risk factor (Bows and Westmarland, 2017; Teaster and Roberto, 2004; Teaster et al 2007; Roberto and Teaster, 2005; Roberto et al, 2007). Conversely, a UK study suggests that women are the main perpetrator for different types of abuse, including discriminatory (60%), financial (54%), and neglect (50%), while men mainly perpetrated sexual abuse (90%), and physical abuse (57%) (Mansell et al, 2009). Information from two LAs in Southeast England was obtained, showing 6148 adult protection referrals were recorded on the adult protection database between 1998 and 2005, in both institutional and domestic settings. Exact figures of the number of older people in care homes is not provided, and thus it is impossible to gauge if these figures are representative of both settings or apply more in one or the other.

Ageing is a factor which can increase the risk of victimisation, but studies are inconclusive on which age brackets are more at risk. O'Keeffe and colleagues (2007) found people aged 66-74 are more likely to report mistreatment, whereas in Naughton and colleagues (2010) those aged 80 and over were most at risk. Likewise, to Naughton and colleagues (2010), SAC data indicates that the risk of abuse is most prevalent in the 85 and above age range (NHS Digital, 2018, 2019, 2020, 2021). Research beyond the UK is inconsistent, with some studies indicating mistreatment is more likely for those under 70 (Acierno, et al, 2010), while others found it is more prevalent for those aged 70 and above (Brozowski and Hall, 2010; Gil et al, 2015). Examining homicide in the UK, Bows and Davies (2019) findings indicate that fatal violence for people aged 60 and over is low in comparison to younger groups. Notwithstanding this, national data indicates that as people age, the risk of homicide increases (ONS, 2020a). In the year ending March 2019, the number of victims in the 55 to 64 age bracket was 48, and in the 65 and above range, it was 92. This was due to a rise in females in this age bracket, which increased by 25 homicides (33 to 58), indicating that homicide against older women is a growing pressing concern. Holt's (2017) findings support this concern, 37 % of female victims were 70 years or over compared to 29% male victims. When studies examine institutional settings, there is inconsistency determining which age range is most at risk. Roberto and colleagues (2007) found that middle aged and older men were significantly more likely to be exposed to unwelcome conversations and sexual activity than younger men, whereas Conner and colleagues (2011) concluded that age is only a risk factor when it intersects with a cognitive impairment. In a meta-analysis carried out by Yon et al (2018), being older than 74 was highlighted as a major risk factor. Poor physical and mental health can increase the risk (WHO, 2021b), and various studies in the UK and beyond have found poor physical and/or mental health is associated with a high rate of victimisation (Fisher and Regan, 2006; Flueckiger, 2008; Luoma et al, 2011; Naughton et al, 2010; Soares et al, 2010).

Katz-Wise and Hyde (2012) point out that identifying as LGBT increases the risk of experiencing victimisation across the life course, but little is known about how sexual orientation and gender identities intersect with the risk of victimisation (Stacey et al, 2018; Woody, 2014). In relation to ethnicity, UK research indicates that victims are more likely to be White, British (Bows and Westmarland, 2017; Naughton et al, 2012;

O'Keeffe et al, 2007). However, this may reflect barriers that make it harder for minority ethnic groups to report violence and/or abuse and does not necessarily mean they are less at risk (Bows and Westmarland, 2017).

3.5.2: Relationship risk factors and community risk factors

A recent report shows that as people age, they are at increased risk of adult family abuse in comparison to younger victims (44% compared to 6%) respectively (SafeLives, 2016). Studies from various jurisdictions have found that the victim usually knows the perpetrator (Acierno et al, 2010; Grossman et al, 20014; Naughton, 2010; O'Keffee et al, 2007). Further, in a quantitative study exploring homicide, it was found that victims and perpetrators are generally known to each other, and that the most common relationship is partner or spouse (23%), then son or daughter (20%) (Bows and Davies, 2019). However, Men were at higher risk of being killed by a stranger (25%), whereas women were most likely to be killed by a partner (38%), or their child (24%).

Bows and Westmarland (2017) findings on sexual violence, indicate that the most common relationship between victims and perpetrators in care homes is unrelated carers. Conversely, SAC data suggests that the main perpetrators of abuse in care homes is service providers (NHS, 2018). Although this information is not disaggregated by age, given older people are more likely to be included in SAC data, it can be inferred this includes older victims. A study carried out by Mansell et al (2009) revealed that most referrals for older people with mental health problems related to abuse by residential or domiciliary care staff/mangers. Research from beyond the UK also indicates that staff are more likely to commit abuse (Goergen, 2001, Goergen, 2004), while others suggest residents are the main perpetrator (Lachs et al, 2016; Myhre et al, 2020; Teaster et al, 2004).

Community factors, especially social isolation can increase the risk of victimisation (WHO, 2021b). Many older people are isolated due to loss of physical or mental capacity, or through loss of family members and friends. Isolation often intersects with other factors that might place older people at increased risk of victimisation, such as a disability (SaveLives, 2017). As older women have a higher chance of being socially isolated (CFAB, 2019a), and more chance of being disabled (Carmel, 2019), their risk of victimisation rises in comparison to older men. Isolation and its link to violence

and/or abuse has recently been highlighted by lockdown measures due to COVID-19 (Age Platform, 2020). These aggravated the isolation in which abuse takes place and made it even more difficult for older victims to seek support.

3.5.3: Socio-cultural risk factors

There is almost always a failure to consider the wider context of historical and structural factors that helps keep violence and/or abuse against older people condoned, hidden, or not taken seriously (Hall, 2014). However, two main factors can be identified in the literature (Pillemar et al, 2016). One of these is how ageism contributes to social acceptance (Nelson, 2005; Sethi et al, 2011; Shepherd and Brochu, 2021; WHO 2021b). Despite recognition of this, until recently there has been little or no appreciation of the significance of ageism when examining victimsation against older people (Shepherd and Brochu, 2021). In a cross-national study of 56 countries, structural ageism was found to be significantly associated with higher prevalence of violence against older people (E-Shien et al, 2021). Congruent with intersectional theories, their findings show that structural ageism coincided with greater inequality in other realms of stigma, for example sexual minorities. Another recognised socio-cultural factor is social and cultural norms (Pillemar et al, 2016). For instance, the normalisation of violence may further perpetuate abusive and/or violent behaviour towards older people (Penhale et al, 2000; WHO, 2021a). Kohlman and colleagues (2014) argue that one of the most influential factors influencing social acceptance of DV, is society's understanding of gender roles and the implications of marriage. This is likely to impact on older women to a greater extent due to generational differences, because women were expected to be subservient to their husbands and endure a certain degree of suffering to maintain the family unit and protect their privacy (SafeLives, 2016). I discuss how these prevent disclosure in section 3.7.1.

Socio-cultural risk factors for institutional abuse include the following:

- Lack of staff and inadequate training (Goergen, 2001).
- Low standards in health care, welfare services, and care facilities (WHO, 2021b).

- Absence of funding to provide good quality care, ageism, and prioritising economics over concern for human welfare (Goergen, 2001)
- An absence of protecting human rights in long term care, such as upholding dignity, privacy, autonomy, participation, and access to justice (European Network of National Human Rights Institutions (ENNHRI), 2017).

While there is recognition of how socio-cultural risk factors impact on EA in institutions, policy fails to acknowledge and address these issues, which silently impact on the delivery of care (Phelan, 2015), such as funding cuts which arguably permits and helps sustain poor standards and abuse in care homes (Bawden, 2017, Burns et al, 2016).

3.5.5: Section summary

Risk factors operate across individual, relational, communal, and societal levels (WHO, 2021b), yet the focus in the UK tends to be on risk between heterosexual partners living in the community. Minority groups tend to be excluded, and institutional settings are often ignored. There has also been a tendency to disregard socio-cultural level risk factors, particularly ageism (Hall, 2014). Whilst socio-cultural risks are acknowledged as impacting on victimisation in institutions, policy does not reflect this (Phelan, 2015).

3.6: Impacts

There is some awareness of the impacts of victimisation on older people. However, most research focuses on heterosexual couples, and there is scant regard paid the consequences for victims in institutional settings. The purpose of this section is to review this knowledge and draw attention to the gaps.

3.6.1: Impacts on older victims

McGarry and Simpson (2011; 2010), explored the impact of DA on 16 older women. They reported significant impacts on their long-term health and emotional wellbeing. The psychological impacts at the time of the abuse, and in later life included panic attacks and acute anxiety. In a later study Lazenbatt and colleagues (2013; 2014) examined the effects of DV on 18 older women. Their stories highlight how mental health issues are prominent effects of DV, with most participants disclosing they had been seriously affected by depression and anxiety. This led to medical interventions

such as taking tranquillisers, antidepressants, and sedatives for decades. A limitation of these studies is they only spoke to older women in heterosexual relationships. Moving beyond this, Mowlam et al (2007), interviewed 37 older people who had experienced mistreatment from a variety of perpetrators. A range of impacts were disclosed including financial loss, loss of independence, social isolation, deteriorating physical health, impact on family relationships, and psychological impacts such as emotional distress, loss of self-confidence/self-esteem, depression, and thoughts of suicide and/or self-harm. Experiences were not restricted to spousal/partner relationships. For instance, a respondent who had been *'drawn into neighbour disputes against their will'* (p.42), disclosed a loss of self-confidence in their ability to judge and manage these kinds of social relationships, and another participant reported the '*shock she felt when something was thrown through her window by local youths'* (p.47). However, while a broader range of perpetrators is included, it is not always possible to ascertain which consequences correspond with what victims and perpetrators, and there is no exploration of the consequences of abuse by children. Research from beyond the UK sheds some light on impacts on mothers who self-identified as having 'difficult' adult children (Smith, 2015). This included self-blame, guilt, depression, and an increasing awareness of mortality due to various types of abuse, such as physical, taking over their space, boundary violations, and feeling disrespected.

Studies from beyond the UK have found a variety of impacts. This includes gastrointestinal syndromes, psychosomatic symptoms, pelvic problems, psychological problems, allergy, weight problems (Stockl and Penhale, 2014), suicidal ideation (We et al, 2013), mental health (psychological distress) (Yan and Tang, 2001), physical health and mental/psychological health (Fisher and Regan, 2006; Olofsson et al, 2012), negative emotional symptoms (Begle et al, 2011), metabolic syndrome (Dong and Simon, 2014), psychological distress (Comijs et al, 1999), physical functioning issues (Cannell et al, 2015), bodily pain, general health issues, vitality, social functioning problems, and mental health issues (Schofield and Mishra, 2004). Studies that investigated mortality as an outcome all unanimously reported higher risks of death among abused older adults (Baker et al, 2009; Dong et al, 2009; Lachs et al, 1998; Schonfeld et al, 2006). While these studies help highlight a vast range of outcomes, most only include women- racial diversity was either limited or not

mentioned, and most were conducted in Western, high-income nations. The intersection with sexuality seems to have been ignored in its entirety. Consequently, we are left not knowing how victimisation impacts on various different groups of people.

While there appears to be an absence of research examining the effects of abuse in institutions, it is not wholly ignored. Emmott (2017), a solicitor, argues that the long-term effects of institutional abuse can significantly impact on survivors mental, social, and physical wellbeing. Ongoing issues include mental health problems and emotional difficulties such as anger, anxiety, or low self-esteem. However, these observations relate to both older and younger victims. Specifically commenting on older people in nursing homes, USA guidance highlights the immediate physical effects of abuse such as: cuts, bruises, injuries, broken bones, and other physical impacts including, substantial weight loss, insomnia, and worsening overall health (NursingHomeAbuseGuide.org, n.d). Psychological consequences such as anxiety, eating disorders, withdrawal and depression, and changes in personality and behaviour are also listed. Somewhat similarly, a range of consequences are highlighted in Grey literature from the USA, including broken bones, bruises, fractures, anxiety, depression, issues with memory, post-traumatic stress disorder, lowered self-esteem, and a tendency to want to remain isolated (Crump, 2023). Depressive symptoms have also been found in a study carried out in Macau and Guangzhou, but there was no significant impact on older victims' quality of life (Wang et al, 2018).

3.6.2: Possible differences in comparison to younger women

Bows (2019b) claims that similar physical and psychological impacts have been identified in research exploring the impacts of abuse and/or violence committed against younger women. As such, it seems older women experience similar consequences. However, the scarce literature comparing effects of DVA across age cohorts suggests the physical health of older survivors can be severely affected in comparison to younger victims, and the impacts of victimisation might be exacerbated by additional psychological burdens (Knight and Hester, 2016). Also, it is more likely for older women to be subjected to victimisation for longer. In turn, this can affect their physical and/or mental health to a greater extent (Home Office (HO), 2014). It is surmised that the longer the abuse has occurred, the more severe the effects are, and

thus older women may suffer more acute consequences (Scott et al, 2008). It is further speculated that because older women are more likely to have been in an abusive relationship for longer, they can have an increased sense of feeling trapped (Knight and Hester, 2016). This potentially enhances the emotional and psychological harm that stems from abusive relationships. The difference between younger and older victims in institution settings seems entirely ignored, but the observations by Emmott (2017) suggest they would be broadly similar.

3.6.3: Section summary

It seems older and younger women experience similar impacts, which includes physical and mental impacts. Nevertheless, the consequences can be heightened by older age and associated conditions, which in turn might create additional negative effects. It is likely that survivors who experience abuse from other family members, such as their children or siblings, suffer similar impacts. However, it seems possible that variations have not been investigated by UK research. Moreover, except for some anecdotal recognition of impacts for victims in institutions, the lived experiences of older victims in these settings seems wholly ignored. More research is needed which explores different forms of victimisation in different contexts (Meyer et al, 2020), which is offered by my study.

3.7: Barriers to disclosure and accessing support

Violence and/or abuse against older people is often unreported (Dow et al, 2019). The WHO estimated that only 1 in 24 cases are reported (WHO, 2021). There are many identified factors which augment elder's silence. A reoccurring theme centres on how generational differences may hinder older people from seeking support. Other reasons include shame, health, cognitive capacity, mobility issues, and disabilities. There are also cultural and religious barriers. All these factors can intersect and create significant obstacles to speaking out and accessing services. The purpose of this section is to examine the factors that prevent older women survivors from disclosure and accessing support and identify where gaps remain.

3.7.1 Generational differences

Prior to the 1970s, a range of social and cultural factors led to many older women suffering in silence (SafeLives, 2016b). Until a legal ruling in 1991 (R v R), it was 'legal' to rape your wife (Vallithan, 2017). Prior to this, case law established a common law exception of implied consent. Further, during the 1970s, DV was not recognised as a social problem and the term itself was rarely used (Blood, 2004). The home was considered a private domain and it was socially unacceptable to disclose issues that happened behind closed doors (Scott et al, 2004). Sexual violence and even sex itself were not openly discussed or acknowledged, because they were private family matters (Mann et, 2014; Vierthaler, 2008).

Research has linked the above generational differences as contributing towards older women's' reluctance to make disclosure or access services. Participants in McGarry and Simpson (2010, 2011) study discussed how historically the home was seen as private, and thus what happened there prevented speaking out. This influences help-seeking behaviour because the home may epitomise a *'safe sanctuary, free from public surveillance'* (Wydall, 2017,p. 254). A high emphasis is placed on maintaining an outward ideal image of a large, cohesive family support system. Consequently, older women are resistant to agency involvement because it is an intrusion into their private lives which threatens to expose a less desirable reality of their family. A recent report highlighted how generational attitudes caused embarrassment to such an extent that one victim remained silent for over 40 years (SafeLives, 2016b).

Generational differences often cause additional shame and stigma. Older women are more likely to have been socialised with traditional values and attitudes regarding gender roles, marriage, and family (Straka and Montminy, 2006). Society created expectations that they would care for their partners and children. This combined with strong taboos around divorce may cause many older women to stay in abusive relationships because leaving is seen as shameful, even when violence is imminent (Zink et al, 2006). For many older women, it is very much *'until death do us part'* (practitioner cited in SafeLives, 2016, p.15). Beaulaurier and colleagues (2005) findings suggest that shame is particularly powerful for older women, and consequently the stigma of divorce or separation is impossible to contemplate. When there is, for example, concerns regarding family honour, the sense of shame might be exacerbated (SafeLives, 2016). Consequently, for older BAME women, especially

those from a religious background, there may be additional pressures to remain in an abusive relationship. Furthermore, examining and comparing the sociocultural factors that influenced elder mistreatment (EM) and help-seeking behaviour among Chinese and Korean immigrants in the USA, Lee and colleagues (2014) indicate EM is a culturally laden construct. Korean participants were less likely to disclose abuse compared to their Chinese counterparts because they were more likely to endorse cultural standards in exclusive family ties and believe in male dominance, and traditional patriarchal values that culturally condoned spousal abuse.

Older women are more likely to have been socialised to be submissive to men (Straka and Montminy, 2006). This can create significant barriers to disclosure, particularly in rural locations (Teaster et al, 2006). In a recent UK study (first of its kind), the National Rural Crime Network (NRCN) found that rural communities are dominated by men and follow a set of age-old, protected, and unwritten principles (NRCN, 2018). Abusers are protected by the isolation of the countryside, and traditional patriarchal attitudes which facilitate controlling and subjugating women. The combination of these factors prevents women of any age from disclosing and/or leaving their abusive partners. However, the findings indicate this may be exasperated for older women. Older women are also less likely than younger women to have economic resources. For many women born before World War 2, financial dependency on their husbands was a widely accepted socio-cultural norm and reflected the differing marital roles for heterosexual partners (Adult Directors of Adult Social Services [ADASS], 2015). As a result, women of this era are less likely to have their name on mortgage deeds, are reliant on their husbands' pension, and have little or no control over the household finances. When abuse is perpetrated by their husband, this can prevent them from making disclosure because they are financially dependent upon their abuser (Nerenberg, 2002).

Many older women grew up in an era when specialist services did not exist. It was not until 1971 that the first refuge opened (Refuge, 2017). As a result, older survivors may be less aware of services available to them when compared to younger woman (SafeLives, 2016). Pritchard (2000) found that older victims frequently remained in abusive situations because they did not know how or where to go to get practical help and advice to facilitate them leaving. More recent research indicates that older women

think specialist services are only for younger women, or women with children (Scott et al, 2004). Their belief is possibly reinforced and maintained by images portrayed in campaigns and the media, which tend to show abused women, as younger women with children. For instance, the zero-tolerance campaign that originated in Edinburgh only included one image of an older woman (Kitzinger and Hunt, 1993). These ageist perceptions are powerful and can convey the impression that abuse does not occur in mid, or later life (Scott et al, 2004; SafeLives, 2016). As a result, older women may face difficulty in identifying they are abused, and even when they do, they are less likely to disclose it and access appropriate services, leaving them vulnerable to dangerous environments.

3.7.2: Health, cognitive capacity, and mobility needs

Health, cognitive capacity, and mobility needs can all create greater dependency on abusers who are providing care (SafeLives, 2016). In a USA study, Zink and colleagues (2003) showed that women remained in abusive relationships due to their health conditions because they were dependent on their abusers, because there was no one else to take care of them When abuse is being committed by adult children, research from Australia indicates that older victims may be reticent to seek support because they are embarrassed to receive help with daily tasks that their child used to undertake and/or because they fear adverse consequences for their child (Dow et al, 2019).

Capacity, such as mobility needs might not necessarily create dependency on the abuser but could still hinder disclosure. For example, physical health can present issues, as leaving the home to access services may be harder (SafeLives, 2016). Alternatively, accessing the community may be difficult due to location. For instance, a USA study found that older women in rural communities faced additional challenges compared to those living in more urban settings, including greater isolation (Teaster et al, 2006) and as noted previously abusers are protected by the isolation of the countryside (NRCN, 2018). When location intersects with health, mobility, and cognitive issues, seeking support is likely to be even more formidable. Victims with communication difficulties can be hindered from explaining their situation (Jones et al, 2006). For example, in a USA study that included domestic settings and institutional locations, older victims who had a diagnosis of dementia were significantly less likely

to self-report abuse in comparison to those without dementia (Burgess, 2006). On the other hand, it may be the abuser who has care needs. Several women in Zink and colleagues (2005) study said they felt committed to caring for their frail partners, which prevented them leaving. Similarly, Scott and colleagues (2004) found that dependency of perpetrators in later life combined with traditional views about marriage and gender roles, were significant factors that caused issues as they had to choose between leaving or fulfilling their 'duty' of caring for their partners.

3.7.3: Financial concerns

Irrespective of age, a significant barrier to leaving an abusive relationship is the limited availability of suitable and affordable housing options, but due to increased financial dependency on their husbands', older women are further restricted in their ability to find affordable housing (Blood, 2014; SafeLives, 2016). For many victims, staying in their home is not safe and they may require immediate safe accommodation which is provided by refuges. However, if older victims need to claim housing benefit to cover the cost, this does not always meet charges, thus leaving a financial deficit (Shelter, n.d). Even when housing benefit is not required, to afford full-service charges and cover costs for essentials, such as toiletries, an extremely profitable pension is needed (Blood, 2004). Finances can deter any survivors from leaving, but for older women who can be less employable, the issue is exacerbated because they are unlikely to ever have the resources to make payments. Many older women did not hold paid employment in their younger years, so even in their preretirement years they are arguably less likely to gain employment because of a lack of work experience (Straka and Montminy, 2006). They are also subjected to ageist employment practices. In comparison, younger women often have workplace skills, can acquire job training, and do not face ageism. As such, the financial barriers that keep younger women in abusive relationships (Kelly et al, 2014), are compounded for older women because they have less employment opportunities and increased dependency on their husbands (Zink et al, 2003).

3.7.4: Reluctance to leave their home and community ties

Solace Women's Aid (SWA) (2016) suggest that in older age people have a greater preference to stay in their home, in comparison to younger groups. However, there is a paucity of research examining the significance of the home for older survivors and

the impact this can have on them leaving. There is also a lack of research exploring the barriers older victims might face when they might have to move out of their community. Examining the meaning of the home for older people (not victims however), Rowles and Chaudhury (2005) suggest that in later life the home becomes the major space where most socialisation and activity takes place. As a result, the meaning of the home is often magnified in later life. Arguably this might make it harder for older women to leave their homes. Moreover, Tomini and colleagues (2016) found that networks of family and friends are an important source of support for adults aged 50 and above throughout Europe, and Age UK (2015) suggest older people place emphasis on maintaining proximity to friends and family. Professionals interviewed in one study believed older victims are fearful of leaving their home because it means rebuilding their whole lives away from their significant close relationships (Bowen and Searle, 2019). Likewise, in a study by Carthy and Taylor (2018), practitioners from the statutory sector assumed that connections to the home and fear of losing social networks strongly influence older victims' willingness to engage with support services. It is unclear from both studies if this is just professions perceptions, or if they were grounded in knowledge gained from supporting older victims. Also, there appears to be no research which explores victims' views. Nonetheless, it seems older victims may have a stronger desire to stay in their home, because they fear losing vital social networks. The pressure to remain in the family home may however come from children, who support the abuser, and believe their mum should maintain the family unit, and thus encourage her to remain (Blood, 2004). It is possible that pressures to remain are linked to traditional gender views and the belief that the family image should be preserved at all costs. A study conducted in Lithuania provides some support for this contention. Mikulioniene and Tamutiene (2019), interviewed 16 older women who had experienced DV and concluded that violence against older women remains invisible due to complex reasons relating to the normalisation of violence. This normalising is interwoven into the idealisation of the patriarchal family model, whereby performance of the wife's and mothers' roles is based on traditional values and her duty to care and support her family. Alternately, the reluctance to leave may be caused by fear of being institutionalised (Council on the Ageing et al, 2000; Schmeidel et al, 2011).

3.7.5: The abuser is their child

Studies outside the UK reveal various factors that may prevent older victims from disclosing abuse by their adult children. An Australian study identified fear of negative consequences (including homelessness) for the abuser, and themselves (Dow et al, 2019). Stigma, shame, and embarrassment at having to receive help with daily tasks after their adult child was removed, were also reported. Other research conducted in New York shows how older victims fear their child would become homeless if they forced them to leave (Smith, 2015). An evaluation report on a DA service for women over 55 (The Silver Project, see section 3.8.3) discussed how the complexities of shame and guilt are enhanced when older women experience abuse by their children, when compared to partner abuse, because they feel that their parenting skills are under scrutiny (Solace Women's Aid, 2016). The limited CTP literature indicates that 'bad parent' discourses are commonplace in society (Edenborough, 2008) which have been infused in a history of neoliberal policy initiatives since the 1990s (Crossley, 2018; Jensen, 2018). Consequently, parents have been constructed as the ones to blame for CTP. Older mothers are affected by the internalised mandate of being a 'good mum' and experience guilt and self-blame when this ideology is not met (Smith, 2020). Likewise, the mandate of unconditional maternal love alongside perceived failures, caused mothers in Nguyen Phan's (2021) study to question their parenting skills and blame themselves. As families are supposed to provide a safe harbour or a place of love and care, the idea of children being violent to their mothers challenges the idealised view of families. Consequently, when children subject older women to abuse, they believe others will blame them for their child's actions, or they blame themselves for 'spoiling' their child when they were younger or because they had to work and leave them with childminders (Smith, 2015). In turn this restricts their willingness to report or name the problem as abuse.

3.7.4: **Section summary**

There are numerous factors that augment older victim's silence. These can intersect and create significant obstacles to speaking out and accessing services. However, much of the knowledge in this area derives from outside the UK. Even beyond the UK there are gaps in understandings. In particular, the significance older survivors might place on their home and how leaving, and possibly losing social networks impacts on their help seeking behaviour, seems unexplored. Moreover, studies in the UK tend to

focus on the abuse of older women by their spouses/partners. This thesis attempts to address some of these gaps and contributes to the emerging literature on ACTP from beyond the UK, and the unpublished research by Nguyen Phan (2021).

3.8: Support needs and support services

Older people, similarly, to younger groups, rarely access statutory agencies directly (Wydall et al, 2015). However, in comparison to younger victims, older victims are also less likely to be referred to specialist services (McLaughlin et al, 2018). As a result, older survivors are underrepresented across both statutory and third sector provisions. and both sectors have limited understandings about their support needs. The purpose of this subsection is to consider literature highlighting the support needs of older survivors and what gaps remain.

3.8.1: Support needs

Pritchard (2000) interviewed 27 older women about their needs for protection and what they required to enable them to come to terms with their abuse. It was further suggested that suggests that older survivors have similar support requirements to younger survivors. Survivors recognised 31 practical and emotional needs, as follows:

- Advice
- Choice/options
- Companionship
- Health
- Hobbies/interests
- Housing
- Information
- Physical help
- Place of safety
- Practical help
- Privacy
- To be believed
- To be listened to
- To be safe
- To talk
- Control over own life/own affairs
- Counselling
- Feeling able to trust other people
- Food and warmth
- People (helpers of various kinds)
- Money/benefits/pension
- Telephone numbers of possible helpers
- To reduce fear of crime
- The support of religious beliefs
- To get out and about
- To forget what has happened
- To stop the abuse/violence
- To feel safe in the house/community
- To protect family/abuser
- To leave the abusive situation
- Who to get help from

Some research suggests that older survivors have similar support requirements to younger survivors (Pritchard, 2000). When victimisation is experienced in institutions there seems to be a significant absence of knowledge regarding support needsAcademic observations from the USA suggest that older victims' needs cover a broad spectrum, including preventing abuse by reducing dependency and isolation, and enlisting help and support using legal interventions to respond to, and stop abuse, assisting survivors' recovery through medical treatment or health care, group or individual counselling, and providing information, advice and support (Nerenberg, 2008). These support needs and those identified by Pritchard (2000) seem similar despite age (Women's Aid (WA), 2021c).

3.8.2: Formal support services

Many women of all ages do not reach out to the police or support services until they reach crisis point (SafeLives, 2016b), but Scriver and colleagues (2013) show that younger women are more likely to report sexual violence to the police or other formal authorities than older victims (33% compared to 16%). Further, while DA incidents are infrequently reported to the police, this is particularly true for older women (Acierno et al, 2001). Older people are less likely to access DA services and be referred to them by other agencies (McLaughlin et al, 2018), and older survivors from minority backgrounds can face additional barriers accessing services due to language and communication issues (CFAB, 2019b). Further, due to increased isolation or a lack of knowledge that specialist services exist or can be used by them, for older victims their first point of contact is often through GPs, health care workers or social services (SafeLives, 2015). Health care professionals are well placed to assess and screen victims of all ages, as well as providing patients with information on available resources (Mouton, 2003; Simmons and Baxter, 2010). However, in Lazenbatt and colleagues (2013, 2014), all 18 respondents said healthcare practitioners, such as nurses and doctors appeared to know very little about support networks and mechanisms to assist them in dealing with issues relating to family violence. Further, Carthy and Taylor (2018), found that non-specialist services do not know what to do when an older client disclosed DA, and could not identify support facilities other than local doctors' surgeries and social services. Participants said they would contact social services to ask for advice if a client disclosed DA. However, as discussed in Chapter 2, the extent they can assist is questionable as social workers are less likely to identify

IPA for older survivors (Yechezkel and Ayalon, 2013). A failure by professionals to refer or signpost older victims to specialist services could leave older victims in danger (Robbins et al, 2016; SafeLives, 2016).

Some older victims do access services and there is some, albeit limited literature exploring how practitioners support them. Rogers and Taylor (2019) interviewed four Independent Domestic Violence Advocates (IDVAs). Their findings suggest that IDVAs may struggle to empower older survivors because they are less likely to want to talk about their experiences, may have additional financial concerns, and might find it harder to make decisions and make changes that end or reduce abuse. While services might face similar issues when working with younger victims, it seems empowering older victims to consider alternative ways of living and help them understand that they do not need to be economically, practically, or emotionally dependent on their partners, is harder. When victims are supported by social services, Butler and Manthorpe's (2016) findings suggest that practitioners feel confident in involving them in decisions when this involved cross-cutting problems, such as DA and coercive and controlling behaviour. An evaluation of if this differs with age was not provided. Consequently, it is impossible to ascertain how participants would have responded when working with older victims, in comparison to younger survivors. Findings from Lonbay (2018), suggest social services assume older victims are too vulnerable to be involved and consequently make decisions on their behalf.

Individuals in institutions can be exposed to various types of abuse, including physical, sexual, and emotional (Yon et al, 2018). It is highly likely that if, for example, a woman is raped in a care home, she will experience trauma, yet research exploring support needs is lacking. Instead, studies seem restricted to exploring preventive measures that minimise risks, improve standards of care, provide clarification for staff, and enable and support the provider to deliver a framework for best practice in care (Chisnell and Kelly, 2019; Elvidge et al, 2009). When studies do consider referrals to other agencies, there is a failure to listen to the experiences of victims and/or survivors, but quantitative findings suggest that referrals for sexual abuse is highest in the 21-30 and 31-40 age bracket (34.2% and 45.3% respectively), and lowest for people aged over 60 (1.2%) (Cambridge et al, 2011). Two-fifths of the referrals related to abuse in

residential settings, but this is not broken down by age, and there is a failure to specify which agencies adult social services referred to.

3.8.3: Tailored support services

Older women's experiences are often exacerbated by social, cultural, and physical factors. Therefore, they often face acute or unique barriers to disclosure and accessing specialist services (SafeLives, 2016). Also, it is likely that older women have been in an abusive relationship for longer, which may lead to an entrenched use of coping mechanisms, such as alcohol or tranquillisers, and they might face greater practical and emotional issues in rebuilding independent living skills and self-confidence (Blood, 2004). Consequently, older women may require support services to be delivered differently (Scott et al, 2004; SafeLives, 2016). While there is recognition that older women survivors possibly require tailored services, there is a poverty of available services specially for older survivors (Scott et al, 2004). The provision of specialist services presents somewhat of a challenge for women's organisations which are, according to Sanders-McDonagh and colleagues (2016) in decline due to austerity. Funding cuts have had a dramatic negative impact on the DA sector, with many funding providers implementing cost-effective solutions (Ishkanian, 2014). Since 2017, there is an identified ongoing trend towards commissioning fewer, yet larger services covering a larger geographical area, that do not specialise in DA provision, such as housing associations (Women's Aid (WA)A, 2018, 2021a). Towers and Walby (2012) argue that generic services, such as housing associations might prompt a downward spiral in the substantivity of women's organisations, thus failing to provide effective responses. Furthermore, they may be oblivious to age (MGarry et al, 2014) and its relevance may not be clear, particularly for organisations that focus on integration and ageless provisions (Knight and Hester, 2016). Consequently, some services are unlikely to fully understand the specific support needs of older victims and be capable of supporting them effectively.

The need for specialist support has been acknowledged in some areas. For instance, in the Northeast (NE) of England, Eva WA opened the first dedicated shared house specifically for women aged 45 and over in 2015 (EVA WA, n.d). From October 2013 to January 2016, 'The Silver Project' worked with 120 older women aged 55 and over, affected by domestic and sexual violence (SWA, 2016). There is evidence that

suggests this service has been successful. An older woman who was surveyed by SafeLives (2016), gave a positive appraisal of her experiences in accessing the project, saying they guided her legally, professionally, and emotionally *'in the right direction'* (p.19). However, there remains a lack of services specifically tailored to older victims (Carthy and Bowman, 2019). Further, the ability to sustain such projects, is a constant challenge in the current financial climate and there is a heavy reliance on funding (SWA, 2016).

3.8.4: Informal support

Mowlam et al (2007) document various types of informal support which helped respondent's cope. For example, voluntary organisations, community organisations, religion, social contacts, and being involved in activities. All of these could be utilised irrespective of the type of abuse, this includes NDA. An older person verbally abused by, for example a neighbour, could seek to mitigate the impact by engaging in community activities. Further, some support could potentially be appropriate for older people in institutions, who have experienced EA. For instance, using religion to cope, or talking to friends and family where possible. The use of informal support networks, by victims residing in institutions seems an unchartered area.

3.8.5: Section summary

Older women seem to have similar support needs to younger victims but may require specialist services to be delivered differently (Scott et al, 2014). However, services are rarely tailored, and it is questionable how far the needs of older victims are met by current DA organisations (Carthy and Bowman, 2019). It also seems practitioners from the health and social care sector, and social services lack the ability to identify and respond to older victims effectively (Carthy and Taylor, 2018; Yechezkel and Ayalon, 2013). This is concerning as these professionals are often their first port of call (McLaughlin et al, 2018). For older victims of abuse committed in institutions, or in the community by, for example a neighbour, there is a significant dearth in knowledge regarding the support they might seek or the types of services they might be referred to help them cope with their abuse.

3.9: Chapter summary

This chapter has provided an in-depth review of the current literature. An interdisciplinary approach was adopted to enable a thorough examination of the extent and nature of abuse and/or violence against older people, the impacts on them, barriers to disclosure, and their support needs. Each section has provided a summary of the main points but to briefly reiterate, it has been shown that estimating the extent of violence and/or abuse against older people is fraught with difficulty, and there is a significant absence of research exploring victimisation in institutions. While there are more studies carried out in the community, they tend to focus on heterosexual partners. Moreover, minority groups are often excluded. This obscures our knowledge about the differing patterns and dynamics of violence and/or abuse older women experience. My study, which listens to the voices of survivors, as well as the professionals who may support them, seeks to ameliorate some of the gaps. In the next chapter I discuss the methodology that guided the conduct of my research.

Chapter 4: Methodology

4.1: Introduction

Methodology is the research strategy that translates the theoretical, ontological, and epistemological principles into guidelines showing how research is conducted (Sarantakos, 2013). The purpose of this chapter is to describe and justify the approach taken in this study, articulate how it fulfils the studies aims, and demonstrate how the methodology is linked to the elements of the project. This chapter commences by reiterating the research questions and aims. Then the theoretical and philosophical framework underpinning the study is described. Next, the research design is set out. The search strategy used to gain literature is then detailed. Following this, the elements pertaining to data collection are outlined and the limitations and strengths of the method adopted is presented. Attention is then given to the ethical issues and how these are mitigated. Finally, the approach taken to demonstrate the validity of the research is detailed.

4.2: Research questions and aims

The justification for my study was provided in Chapter 1. Chapter 2 and 3 explored the gaps in research. An emerging key theme was that there is an absence of studies listening to the lived experiences of older victims (Carthy and Taylor, 2018; Wydall et al, 2019). There is also a dearth of research exploring the experiences of DVA practitioners and social workers, when working with older victims (Bowen and Searle, 2019; Carthy and Bowman, 2019). To address the gaps, this study sought to listen to the voices of abused older women, and practitioners, with a view of exploring their subjective experiences. The underlying theoretical and philosophical assumptions, which are discussed in section 4.3, alongside recognition of gaps in knowledge, led to the formulation of two overarching research questions and seven aims that seek to answer these questions.

1) What is the nature and impact of violence and/or abuse against women aged 60 and over?

I: What types of violence and/or abuse are experienced?

II: What factors impact on experiences of victimisation, and to what extent do they act as barriers to leaving and/or seeking support?

III: What is the impact of violence and/or abuse?

IV: What services and/or support networks do older survivors access and what are their experiences of this?

2) What can the experiences of professionals from social services and DVA organisations tell us about violence and/or abuse against older women?

V: How do DVA organisations and social services recognise and respond to victimisation against older women?

VI: What challenges do services face when working with older survivors?

VII: Do support needs of older victims differ from younger survivors?

4.3: Theoretical and philosophical framework

An intersectional feminist framework that is informed by social constructionism is adopted for my study. The purpose of this section is to detail the theoretical, ontological, and epistemological framework and assumptions underpinning this study.

Although violence and/or abuse can affect both men and women in later life, research and official data continuously indicate that older women are more likely to be victims than older men (Bows and Westmarland, 2017; Naughton et al, 2020; NHS Digital, 2019; NHS Digital, 2018; O'Keeffe et al, 2007; ONS, 2019a). Thus, the significance of gender cannot be disregarded and violence and/or abuse in later life, likewise to younger groups, can be seen as a form of victimisation against women. Feminist interpretations of DV, now more commonly referred to as DA or IPV (which I collectively refer to as DVA), were forefront in challenging existing theories of DV (Houston, 2014). As a result, there was a shift in how society thinks about violence

and/or abuse against women, and it is now recognised as a public matter warranting State intervention. Nonetheless, as Davies (2018) points out:

> *'As a theoretical perspective, feminism is a slippery and amorphous perspective to define* (p.289)*'*.

This is because there are several feminist perspectives which vary in their outlook. While each perspective differs, they are underpinned by common commitments (Davies, 2011). On a political level, feminist approaches challenge the conventional agenda and advocate for equality. On a substantive level, gender is a focus of analysis. This impacts on methodology because research is conducted for women, not on women (Cook and Fonow, 1990). The emphasis on gender inequality and challenging this (Chesney-Lind, 2006; Schecter, 1982) makes a feminist framework approach suitable for my study.

Feminist research has been criticised for not representing all women. In the 1970s, feminists of minority groups noticed that their experiences were underrepresented within mainstream feminist dialogue (Chesney-Lind, 2006). Subsequently, forceful criticism was charged against their majority-group counterparts for maintaining to communicate on behalf of all women and the term intersectional was devised by Crenshaw (1991). While intersectionality seems to lack an agreed definition (Davis, 2008), it is accepted that this approach recognises that systems of power such as race, class, and gender interconnect and are axes for analysis (Nash, 2008). Emphasis is placed on a power hierarchy, whereby individuals are socially positioned in relation to their differences from each other. This structural pattern affects access to institutional power and privileges (Anderson and Collins, 2004). The emphasis on power and privilege allows for a perspective of how women and men can simultaneously experience both privilege and oppression throughout the life course (Daly and Stephens, 1995, May, 2015). Brah (1991) highlighted this by illustrating her own status as a British Asian woman. She pointed out that while she is subjected to racism, she also, as a member of a dominant caste in her community, holds a position of power in comparison to lower caste women. Intersectionality recognises that the social hierarchies through which we are socially located differ from each other, they do not all share the same ontological foundation, and they are not all established on the same social relations (Yuval-Davis, 2006). As such, it acknowledges that social

categories, such as gender and age have different symbolic meanings that are dependent on the social conditions in which they operate (Anthias, 2001).

An intersectional approach allows for a more nuanced understanding of people and their positioning in social hierarchies (Crenshaw, 1991; Crenshaw, 2003). It calls attention to how women's experiences of DVA are not limited to gender alone. Despite recognition of the importance of intersectional approaches to understanding victimisation, research has, in the main, ignored the overlap of age and gender and mainly focused on ethnicity, race and sexism (Bows, 2019b). However, its ability to consider age, alongside other inequalities has not been completely ignored. O'Brien (2016) used intersectional analysis to examine the discursive relationship between age, gender and class and the high level of risk for survivors and perpetrators. While this study is limited to adolescents, this application shows how intersectionality can be used to explore the connection between DVA and age. Academic observations have stressed the importance of considering age and ageism when examining violence and/or abuse against older women (often calling it EA). Nerenberg (2002) argues that it is essential because EA represents a convergence of gender and age-related factors, which together compromise older women's ability to achieve or uphold self-sufficiency. Penhale (2003) suggests that it is important to consider ageism when examining EA as it may increase its risk:

> '…the routinized devaluation which elders experience from living in an ageist society can exacerbate vulnerability which may already exist due to deterioration in physical and mental health. The risk of abuse may thus be increased for individuals.' (p 179)

Recognition of the impact of age and ageism is thus necessary to establish the extent these both perpetuate abusive situations and act against their resolution (Penhale, 2003).

Scholars generally agree it is necessary to consider how age and gender, and the associated inequalities of both, intersect with victimisation (Nerenberg, 2002, Penhale, 2003). However, the aetiology of victimisation against older women is complex and involves a multiplicity of factors stretching beyond sexism, and ageism. It can include the intersection of various characteristics due to accumulated discrimination across the life course (Help Age International (HAI), 2017a). Characteristics, such as lower

literacy levels, disability, and living in rural areas, have been highlighted as placing older women at higher risk of victimisation (HAI, 2017b). These socio-structural factors are recognised as contributing to many aspects underpinning EA (World Health Organization (WHO) and International Network for the Prevention of Elder Abuse (INPEA), 2002). It is thus essential to allow for consideration of the complex interplay of these various factors, as they set the context for abuse to occur and can prolong exposure to it. Therefore, when examining abuse against older women, a framework that enables exploration of the economic, social, and political status of women and older people, alongside the cumulative impacts of sexism and ageism is necessary (Nerenberg, 2002). Intersectionality has the capacity to accomplish this. It erases binary understandings by taking account of the various complexities of life (Crenshaw, 1993). In doing so, it facilitates a more nuanced understanding of abuse against older women and draws attention to the root causes of the problem.

Violence and/or abuse against older people involves an imbalance of power relations, with those at greater risk often being in relatively less powerful positions than perpetrators (Brandl and Razwadowski, 2003). Those who abuse older people do so because they have the power to, often believing they have a right to control them. Older victims either lack the power to stop victimisation or due to age-related dependence, disability, and other possible sites of inequality are unable to exercise power to prevent abusive situations or escape them (Westwood, 2018). Intersectionality acknowledges that social categories are both properties of individuals and characteristics of the social context (Else-Quest and Hyde, 2016). Each category is embedded with inequality and power. This emphasis helps to uncover the dynamics that shape victimisation and resilience to it (Chaplin, 2019). It thus fosters a better understanding of the context of abuse, including whether it is a pattern of continuing abuse, and if it is perpetrated within a relationship of power and control. It has the potential to explore differences between victimisation that is committed by partners compared to, for example neighbours, and has the potential to highlight possible variations between community settings and institutions. While the focus of my research is on female victims, it is worthy to note that the emphasis on power and privilege allows for an examination of how both women and men can simultaneously experience privilege and oppression (Daly and Stephens, May, 2015), and how some benefit from the oppression of others, who occupy lower social positions (Burgess-

Proctor, 2006). Intersectional theory can therefore be used to explore how intersecting inequalities such as disability, and race, place some older men more at risk, in comparison to other men. It could also reveal if their perpetrators occupy a higher privileged status.

Feminist research tends to have emancipatory features and thus, most feminists take a personal, political, and engaging stance (Sarantakos, 2013). By drawing attention to the social and political contexts that reinforce power relations, and by revealing processes of resistance, intersectional approaches can help eradicate inequality (May, 2015), such as ageism, and may serve to recognise and promote the human rights of older victims (Penhale, 2003). Tacking such an approach has been recognised as key to tackling EA as it supports challenging negative social norms about ageing and promotes the dignity of older people (HAI, 2017a). Moreover, understanding victimisation against older people as a human rights issue, is a further step in the application of critical criminology because it allows for consideration that goes beyond seeing it as a discrete offence or set of offences designated by criminal law (Hall, 2014). It facilitates an understanding of how inequalities such as sexism, ageism, racism, homophobia, biphobia, and transphobia perpetuate abusive situations, and may prevent some older people from seeking support. By challenging inherent perceptions of gender, age, and other sites of inequality, an intersectional approach can promote structural changes to help combat violence and/or abuse, and challenge societal norms that encourage and even condone it (Penhale, 2003).

The importance of using a framework that enables exploration of how age and ageism might impact on victims, is highlighted when considering how services recognise and respond to violence and/or abuse against older women. Polices, priorities or strategies often ignore the intersectional needs of many women (Crenshaw, 1991), including older women (SafeLives, 2016). Services taking an intersectional approach are better equipped to appreciate how experiences of abuse are unique to people's histories and identities (Bernard, 2020; Crenshaw, 1991, 2003). Understanding how multiple factors affect experiences of abuse, as well as the barriers to help seeking, helps provide insight into appropriate interventions. Furthermore, ageist views and accompanying perceptions can impact on the ability of professionals to recognise and respond to victimisation against older women (Albiston, 2013; Blood, 2004; Bows and Westmarland, 2017; Carthy and Bowman, 2019; Fileborn, 2016; Lanzenbatt et al,

2013, 2014; SafeLives, 2016; Sharps-Jeffs and Kelly, 2016; Southend Safeguarding Adults Board, 2011). Intersectionality recognises that while there is unequal power, there is some degree of agency that individuals can exert (Crenshaw, 1991). This encourages services to acknowledge the importance of giving older people choice and control over services they receive, offers a way for practitioners to build strengths-based relationships with survivors, and empower them (Bernard, 2020, Chaplin et al, 2019). In doing so, older victims can be supported by professionals to pursue appropriate action, as opposed to them assuming they are too vulnerable to be involved (Lonbay, 2018).

Intersectional methodology is somewhat unexplored (Day, 2020). However, postulations on this are not wholly absent. Else-Quest and Hyde (2016) discuss positivism, social constructionism, and standpoint epistemology and analysis how compatible these are with an intersectional approach. It is outside the scope of this chapter to detail these methodologies and their merits, but it is contended that social constructionism is well suited. Hall (2014) advocates research taking this perspective when examining EA is needed, and this epistemology was recently used to explore different understandings of EA from a variety of actors, in rural and Urban Zambia (Kabelenga, 2018). Social constructionism contends that knowledge is derived from people interacting with each other and reaching an agreement on facts and ideas about the world (Galbin, 2014). Individuals socially construct their view of reality from their daily, direct experiences, and from information they pick up symbolically through language and images, other people, and the media. Language and body language reflect people's values, which are dependent on geographical location, and other factors, such as events occurring in and around the time frame they exist in (Gergen, 2001). Constructions of reality are thus influenced by symbolic interactions and by culturally specific knowledge. As a result, characteristics that are typically thought to be solely biological, such as gender, class, and age are not immutable. This belief fits well with intersectional theory and allows for an examination of how victimisation against older people is a social construct that is understood and experienced in multiple ways (Kabelenga, 2018). This permits an exploration of the different realties people perceive, and how unique experiences throughout their life course have shaped these.

Within the process of constructing social reality, competing constructions are put forward (Galbin, 2014). Claim makers advocate that their reality should be adopted by others. This includes assertions about violence and/or abuse, which gain their status through a process of effective claims made by social movements and/or groups that have advanced definitions and sought to mobilise certain kinds of responses (Gergen, 2001). Over time, these claims are translated into formal terminology that is conveyed in Acts of Parliament, government guidelines, good practice guides, or other official ways, and support organisations and mandates may be created to assist victims. For instance, there are DVA organisations seeking to support victims and the Care Act (2014) placed safeguarding on a statutory footing. As discussed in Chapter 2, there are however identifiable differences between how DVA and safeguarding came to be recognised as social issues, which has impacted on how they are responded to politically and practically.

Exploring violence and/or abuse against older women, through an intersectional feminist perspective that is informed by social constructionism, provides a critical perspective that questions notions such as gender, old age, and vulnerability by reflecting on how they are social constructs (Hall, 2014). In doing so, it unveils explicit and implicit assumptions about categories and avoids essentialist notions that inevitably blame vulnerable and marginalised people for their abusive situations. Further, it allows for an examination of how intersecting factors and experiences may hinder older victims from seeking support. Moreover, its ability to challenge inherent perceptions of inequalities, coupled with the recognition that individuals have agency, facilitates services to acknowledge the importance of older people as having choice and control over the services they receive. It also enables services to better understand survivors and their specific needs (Bernard, 2020; Crenshaw, 1991, 2003). As explored in the next section, this combined framework recognises that those who have experienced violence and/or abuse, observed it, or confronted it are in the best position to shed light on the phenomena (Kabelenga, 2018).

4.4: Research design

This is a qualitative study that utilised unstructured interviews to gain data from three groups: older victims, DVA professionals, and social workers. Feminist researchers have focused on listening to survivors' stories, with the aim of shaping responses and

services (Oakley, 1981). Interviewing is appealing because it helps access people's ideas, thoughts, and memories (Reinharz, 1992). Similarly, social constructionists prefer methods that allow individuals to express their experiences, in their own words (Creswell, 2013; Allen, 2004). Often people's narratives are marginalised, suppressed, and rejected in favour of dominant belief systems (Dickerson and Zimmermann, 1996). Listening to people's stories can provide a challenge to the oppressive domains of knowledge construction and facilities change (Coale, 1994). Both feminist researchers and social constructionists are keen to pay heed to the voice of individuals and how their stories are constructed within a particular system, with a view to eliciting change to dominant power structures (Shulamit, 1992; Allen, 2004; Westmarland, 2001). Thus, the method and methodology is ideal for my research as it allows for an exploration of how participants perceive their experiences, with a view of using their stories to advocate for change at a political and societal level.

There are several types of interviews, but Sarantakos (2013) highlights three main types: structured, semi-structured, and unstructured. The main difference between them is the extent respondents maintain control over the process and content of the interview. As my study sought to listen to the subjective views of survivors and practitioners, unstructured interviews were utilised. This allowed maximum freedom for respondents to tell their story in their own words, which is an intrinsic aim of feminist research (Reinharz, 1992), and preferred by social constructionist epistemology (Creswell, 2013; Allen, 2004). Furthermore, research carried out by Minocha and colleagues (2013) suggests that older people prefer conversations with researchers, rather than following a structured interview because it allows them to relate their stories. To further promote the voices of my participants, I used a narrative style of unstructured interviewing. This style has been recognised as placing the people being interviewed at the heart of the research study (Anderson and Kirkpatrick, 2016). Further,

The considerations noted above underpinned the design of the interview schedule. A narrative interview consists of researchers asking open ended questions which invites the interviewee to respond by retelling experiences of events they have experienced (Stanley, 2018). Some feminist researchers favour the use of open-ended questions because it reduces the danger that questions might impose external meanings and interpretations on respondents' experiences and views and allows investigators to

make full use of any variations participants express (Reinharz, 1992). As intersectional feminism focuses on exploring differences (Nash, 2008) this style of questioning was particularly suitable for my study. Likewise, from a social constructionist view, interviews employing open-ended questions are beneficial because they allow participants to fully describe their experiences, which helps uncover their often marginalised and suppressed views (Creswell, 2013). Moreover, this narrative approach allows respondents to maintain maximum control over the information given and may reduce the chances of providing responses they feel are expected. In turn, this helps reduce power imbalances (Stanley, 2018). The interviews also had a life history element. This allowed me to contextualise the findings in the wider historical, social, and political context of the time (Sarnecki and Carlsson, 2018). The analytical framework supports this method, because both intersectional feminism and social constructionist epistemology can be used to examine how the nature of power can change over different times and in different contexts (Allen, 2004; Nas, 2008).

4.5: Search strategy and selection criteria

As discussed in Chapters 1 and 2 there is no single definition for violence and/or against older people. Thus, when searching the literature, no constraints were placed on definitions, by, for example, only including literature that utilised Action on Elders (AoEa) (1993) definition (see Chapter 2 for definition). A wide variety of initial terms were used. When considering specific areas, such as abuse and/or violence against older people in care homes, other terms were added to the initial terms (see Table 6 for examples). Chapter 1 justified why I define 'older' as 60 and over. Nevertheless, research including respondents aged 50 and above was included. In doing so, the lower age limit adopted in some existing investigations is reflected (Baker et al, 2009; Council on the Ageing (Australia) et al, 2000).

Table 6: Non-exhaustive list of search terms

Initial terms	Added terms
Elder abuse/ violence/ mistreatment/ maltreatment. Abuse/ violence/ mistreatment/ maltreatment + older/ elder/ elderly/ aged. 'Later life' + abuse /violence /mistreatment / maltreatment. Domestic violence/ or DV/ + 'later life'/ older/ elder/ elderly/ aged. Domestic abuse/ or DA / + 'later life'/older/ elder/ elderly/ aged. Interpersonal violence/ or IPV + 'later life'/ older/ elder/ elderly/ aged. Older/ elder/ elderly/ aged/ 'later life' + above, ie - + abuse/ or + IPV Adults at risk	+ lesbian +/gay +/bisexual +/transgender + LGBT/minority.
	+ care home(s)/ residential care/ institutions.
	+ prevalence.
	+ vulnerable/frail
	+sexual violence/ abuse/ mistreatment/ maltreatment
	+ physical violence /abuse /mistreatment /maltreatment.
	+ psychological abuse/ mistreatment/ maltreatment.
	+ financial abuse/mistreatment/maltreatment.
	+ neglect or acts of omission
	+ safeguarding

Research and literature exploring victimisation against older groups is somewhat fragmented, existing in the pockets of many fields (Bows, 2017a). This includes but is not limited to, EA, gerontology, criminological, nursing, social work, family violence, and public health fields (Allcock, 2018). While there are overlaps, the fields have evolved separately and seem to continue to be treated as distinct (Bows, 2017a). For instance, Bows (2019a) points out that DV studies are primarily aimed at feminist practitioners and scholars, whereas EA studies are targeted towards the social work,

health, and social care sector. Therefore, to gain literature on violence and/or abuse against older people, an interdisciplinary approach was adopted which overlaps and traverses somewhat rather traditional boundaries. To enable cross fertilisation, several sources were used, including:

- PubMed (central & Medline).
- CINAHL.
- Cochrane library.
- Taylor & Francis.
- ProQuest.
- Scopus.
- Science Direct (health professions).
- EBSCO Academic Bool Collection.
- JSTOR (Arts & Sciences).
- Elsevier Health and Medical Collections.
- Snowball sampling of references in relevant articles.
- Google search to find grey literature such as Government reports, policies, legislation, research reports, and advice and guidance fact sheets.

Studies prior to 2000 were, in general, excluded. However, if, for example, there was no published research after 2000, an exception was made, and it was noted that the study was 'dated'. Exceptions were also made if a 'dated' study was required for historical comparison. As, at points, a historical account is taken, academic observations and grey literature could be 'dated'. However, when discussing the contemporary position, work prior to 2010 was disregarded. The focus is on the UK, but literature from other countries was considered.

4.6: Data collection

Data collection involved interviews with three groups, older women survivors, social workers, and professionals from DVA services. Unstructured interviews were used with the aim of exploring the nature and impact of violence and/or abuse (self-defined) against women aged 60 and over. This method was also employed to examine what the experiences of practitioners from social services and DVA organisations can tell us about violence and/or abuse against older women. The sampling strategy, interviews, analysis of data, and the approach to data collection is now discussed.

4.6.1: Sampling

Researching victimisation against older women involves examining a 'hard to reach group'. A 'hard to reach group' is any group which is difficult to access and includes victims, and older people, especially those that are frail and/or isolated (Deakin and Spencer, 2018). Considering this, consultation with the Growing Old Living in Darlington (GOLD) project was undertaken, with the aim of increasing participation. GOLD is made up of gatekeepers and members who are all over 50. Their project seeks to provide a brighter, active, and more positive future for people aged 50 and over. Meetings with GOLD took place to discuss ways to effectively communicate with older people. Their input helped inform the design of adverts and all documents given to participants.

Survivors' sampling

A purposive, snowballing technique was used to recruit older survivors. This form of non-probability sampling does not provide representative samples but ensures respondents have relevant experience, which achieves *'maximum precision within a given sample'* (Francis, 2018, p.53). To facilitate this, an inclusion criterion was devised (see Table 7 below). Those who agreed to participate were also asked if they could recommend anyone else who might participate, and many organisations were asked to recommend respondents. This process is known as snowballing (Sarantakos, 2013).

Table 7: Inclusion criteria for survivors

Inclusion criteria
Must be 60 or over. The violence and/or abuse (self-defined) must have occurred at some point after turning 60 but this can have commenced before turning 60.
Be female or identify as female.
Can understand the purpose of the study, expectations, and are able to provide informed consent.

Survivors were approached through a range of ways. Uptake of support services by older women, might be higher when DA services are advertised:

'in places where older women might go either for help or in the course of their daily routines.' (Blood, 2004, pp.17)

Organisations such as the Citizens Advice Bureau (CAB), GP surgeries, community centres, post offices, and age-related organisations were identified by Blood (2004). Considering this, over 80 organisations were contacted, including the CAB, local Doctor surgeries, National Age UK, Salvation Army, care providers, local community centres, and DVA support services (see appendix 1). Many did not respond, and some responded with reasons why they could not support the request, such as lacking resources. The refusals from Silver (service that supports older victims in London, see Chapter 3), National Age UK, and EVA (a refuge that has a specific section for women aged 50 and over, see Chapter 3), were particularly disappointing because it was anticipated their endorsement might have increased the sample range. Involvement with Silver may have led to a more diverse sample range, as 60% of older women supported by their service, from October 2013 to January 2016, were from BME backgrounds (SWA, 2016). Despite a high number of refusals and lack of responses, the research was widely advertised, especially in the Northeast, due to local knowledge and opportunities to network. Networking sometimes led to permission to advertise, or access to participants. Other methods were also used to gain participants, for instance a post on Grasnet, a website and forum dedicated to older people, through a local newsletter distributed by GOLD, on Research Gate, and through social media sites, such as Twitter, and Facebook.

Respondents were mainly recruited via referrals, either through support organisations or their friends. 13 older women were interviewed, all were White British. Ideally the sample range would have been more diverse, but there were differences in their current age, social class, religion, and if they classed themselves as having some form of physical and/or mental disability (see appendix 2). Most interviews were conducted in participants' homes, following an amendment to the initial ethics application (see section 4.7).

Professional's sampling

A purposive, snowballing technique was used to recruit both social workers and DVA professionals. This form of non-probability sampling does not provide a representative sample, but it did ensure that both groups of practitioners had some experience of working with older victims. To facilitate this, an inclusion criterion was devised (see Table 8 below). Those who agreed to participate were asked if they could recommend other professionals, thus adopting a *'snowball'* approach (Sarantakos, 2013).

Table 8: Inclusion criteria for services.

Inclusion criteria
Must currently work in a DVA organisation or social services.
Must have some experience of supporting older women victims.
Can understand the purpose of the study, expectations, and are able to provide informed consent.

Professionals were approached through similar means as survivors. Most of the 80 organisations contacted were also asked to promote the research to either staff that worked in their organisation (when, for example the email was sent to a DVA service) or to forward it to organisations who may know possible participants. It was foreseen that a CAB, for instance, may be aware of DVA support services in their local area. To further promote participation, an interactive workshop on violence and/or abuse against older women was delivered at a social work conference at the University of Northumbria Newcastle (NU). The conference was well attended by social workers. Following the session, participants were informed of the study, and asked to indicate their interest in participating. In addition to this, for social workers, a permission email was sent team managers asking them if they would take part and/or refer staff members.

Three professionals from social services were recruited from the Northeast who had attended the social work conference previously mentioned. Seven social workers were recruited through permission emails sent to the team manager. All 11 DVA practitioners were recruited via email contact with the organisation they worked for. 20 out of 21 participants were White British. However, their job role, length of experience, and geographical location varied, which helped gain diversity (see appendix 3).

4.6.2: Interviews with survivors

My study listened to the voices of 13 older victims. Previous research indicates that older women do not necessarily perceive their experiences in line with set definitions (Council on the Ageing (Australia), 2000; Mann et al, 2014). Consequently, no definitions, such as DVA were imposed. Instead, open questions were used which permitted discussing their self-defined experiences of violence and/or abuse. An interview schedule (see appendix 4) was developed for use with all survivors. The first part asked personal questions such as their age, racial identity, social class and if they classed themselves as disabled. These introductory questions were used to build rapport and to enable analysis of possible intersecting inequalities. The main part of the schedule was un-structured in nature, and the open questions were guided by the first research question and corresponding aims. While the focus was on experiences past 60, respondents were also asked to reflect on experiences before they turned 60. To ensure past and present experiences were not confused, if, at any point, I was unsure if their stories related to past experiences, or since turning 60, clarity was sought.

All participants requested face to face interviews, and most lasted an hour and a half. This included, as detailed in section 4.7, a period for emotional recovery. Some respondents showed some emotional distress from retelling their stories, but all wanted to continue, despite being offered the option of stopping the interview. It seemed they wanted to tell their stories when they were provided with the opportunity to do so in a safe space. Previous research has observed that older victims are likely to talk about personal abuse if they are provided a safe space and chance to do so (Mears, 2003).

4.6.3: Interviews with professionals

Interviewing professionals who work with older survivors allows researchers to obtain rich information from people who have observed it (Kabelenga, 2018). Practitioners have a variety of experiences and can often recognise good and bad practice that can be used to inform current and future service provision (Carthy, 2019). They can also provide information regarding challenges services face when assisting older victims and insight into institutional barriers that restrict the availability and efficacy of services (Ullman and Townsend, 2007). Their perspectives on the impacts of violence and/or abuse against older women, and the challenges faced in accessing and providing services may help reinforce the recent calls to increase awareness of this phenomena, and improve responses (Bows, 2017b; Age Platform, 2017).

The same interview schedule was used with both social workers and DVA practitioners (see appendix 5). To build rapport, participants were asked three general questions about themselves. Following this, open questions were asked which were guided by the second research question and accompanying aims. The first question asked about their experiences of working with older survivors of any type of violence and/or abuse. To ensure professionals' conception of older people met the definition of older, imposed in this study (60 and over), this question asked them to discuss their experiences of working with victims aged 60 and over. Other than this exception, no definitions were imposed.

Prior to Covid restrictions, all interviews took place at participants' workplaces. Following this, all interviews took place via Microsoft Teams. Interviews lasted about an hour, which as discussed in section 4.7 included a period for emotional recovery.

4.6.4: Analysis of interview data

Survivors and practitioners were interviewed. In total there were 34 participants (13 older women, 11 DVA practitioners, and 10 social workers). This produced a large amount of rich, raw data. Thematic analysis informed by intersectional feminism and social constructionism was employed to analyse findings. Thematic analysis enables researchers to move away from mere descriptions of patterns within data to a critical examination (Braun and Clarke, 2006). Thus, the process of thematic analysis is

appropriate to critically analyse the various experiences and views of all my sample groups.

Acknowledging the criticisms against thematic analysis because it does not contain clear guidelines, Braun and Clarke (2006) developed a six-phase guide to undertaking such analysis, whilst maintaining the flexibility intrinsic to this approach. This six-phase guide, alongside how I approached it is now set out.

1) Familiarisation with data.

A dictaphone was used to record interviews. Permission to record interviews was sought during the consent process and confirmation of this was indicated on the consent form (see appendix 6). All recordings were transcribed verbatim. To facilitate familiarity notes were taken and audio-recordings were listened to twice. The first hearing primarily promoted gaining an overview of the interview, its tone, mood, and dynamics, while the second allowed the data to be scrutinised in more detail (Talmage, 2012). In addition to this, transcripts were read several times. Familiarisation with the data also enabled me to search for patterns across the data sets that were relevant to the research questions and aims. The initial codes and broad themes that became familiar are detailed below.

2) Generating initial codes that relate to the research aims.

Data was synthesized using computer assisted qualitative data analysis software, namely NVivo. This involved systematically working through the transcripts and attaching a descriptive label (initial coding) by using the coding function in NVivo. For instance, an initial code of 'types of abuse and/or violence' was used when survivors discussed their experiences of victimisation. In doing so, codes reflected the context of the data.

3) Searching for candidate themes across each of the codes

To gain key themes from the data, I looked for areas of similarity and overlap between codes, as well as exploring concepts, topics or issues that underpinned several codes. Braun and Clarke (2006) suggest that a theme should capture a significant aspect of the data in relation to the research question. To facilitate this, I searched for larger patterns that were meaningful to the research aims across all transcripts. An example

of an emerging pattern was how all 13 survivors mentioned age when discussing their experiences, albeit in different ways. Further, when highlighting challenges, they may face when supporting older victims, both sets of practitioners discussed age. Again however, how this factor was perceived varied. A code was created for age, subcodes were developed, and the differences were reflected upon in the write up.

4) Reviewing themes

Themes identified in phase three were reviewed. Consideration was given to how they reflected the meanings in participant's accounts. Transcripts were reread to check the themes captured the narratives of participants. For instance, it was initially assumed experiences of victimisation would be the main driver behind how older women victims conceptualised their experiences. An initial code was devised to capture this (type of victimisation and the impact). However, further analysis indicated that instead, the differences in experiences were heavily dominated by who the perpetrator is. The type of perpetrator affected the impact of victimisation and the types of services and or support networks accessed. This led to a new overarching theme (types of perpetrators and how this affected survivors).

5) Defining and naming themes.

Extracts from participants' stories were used to describe and interpret each theme. For example, when talking about different factors that affected their experiences of victimisation, all participants reflected upon age, most also told me about other factors such as health and dependency, and eight women discussed victimisation that had occurred before they were 60. Corresponding with their narratives and aims of the research, the overarching theme was entitled 'factors that impacted on experiences of violence and/or abuse'. The sub themes were called age; generational differences, intersectional identities, dependency, shame, stigma, financial reasons, physical add/or mental health, and experiences prior to turning 60. During this stage, to aid analysis, links to relevant literature were made. Following the presentation of findings, these were discussed in line with the theoretical and philosophical framework my study is set within.

6) Capturing the narrative of the data and convincing the reader of its importance and validity of the analysis.

Extent was indicated by presenting data in a table format or noting the number of respondents who expressed a view by, for example (n6). Quotes from participants' accounts were used to demonstrate the essence of each theme and illustrate their narrative. In doing so, the results move beyond description and the findings can be judged in relation to how far they answer the research question and aims. While data was transcribed verbatim, parts of quotes were removed to aid readability.

4.6.5: Limitations and strengths of the method

Feminist methodology recognises there are strengths and weaknesses with all methods that cannot be completely controlled by the research process (Cook and Fonow, 1990). Thus, the aim of this section is to highlight the strengths and weaknesses of unstructured interviews.

Unlike structured interviews, unstructured interviews are not easily replicable (Stanley, 2018). Each interview is unique, and it is unlikely that other researchers will be able to copy the process and arrive at the same results. This method is therefore criticised for lacking reliability. However, I was less interested in replicating findings. Instead, my aim was to explore subjective experiences of victims and professionals. However, to mitigate issues, where possible, findings were compared to previous literature. Unstructured interviews are somewhat time consuming and may require finances to travel (Sarantakos, 2013). My project plan allowed for lengthy interviews, and finances were available for potential travel costs. Any type of interview can be impacted by researcher bias (Sarantakos, 2013). Confirmation bias happens when researchers use respondent's information to confirm their views or beliefs. Attempts to minimise this were taken. For instance, non-leading and open questions were used, summarising respondents' comments was avoided, and responses were never elaborated upon (Braun and Clarke, 2013). Additionally, the process of reflexivity was adopted (see section 4.8), I sought to ensure participants' narratives were reflected, and invited participants to make comments on the analysis of data. Four of the women interviewed took part in this process and told me they agreed with how their narratives had been used. Another limitation of interviews is their retrospective nature which relies on the recollection of the interviewee to recall experiences which might have

occurred a long time ago (Sarnecki and Carlsson, 2019). This can make the sequencing of life events hard to decipher and it is feasible that some information may be forgotten. However, my respondents were not required to give a full account of their experiences, it was enough for them to discuss any they deemed relevant, and except for clarifying whether victimisation occurred before or after the age of 60, participants did not have to provide an accurate timeline. To ensure differentiation could be made between experiences prior to turning 60 and after, as detailed in section 4.6.2 clarity was sought. Further, the power hierarchy present in interviews is often seen as a possible limitation. Most of the power within interviews is held by the interviewer (Stanley, 2019). Unstructured interviews provide the most control for participants, which in turn, helps reduce power imbalances.

It is evident that there are limitations of using unstructured interviews, but as detailed above steps were taken to alleviate these. Despite their limitations, they were ideal for my study, because they provide an indispensable tool which facilitates hearing the stories of often marginalised groups, such as older victims and help facilitate social change (Coale, 1994; Chesney-Lind, 2006; Schecter, 1982; Westmarland, 2001).

As acknowledged in section 4.6.5 the sampling strategy does not provide representative samples. Also, due to the small sample range, the findings from this research can not necessarily be applied to other older victims, and practitioners that seek to support them (Sarantakos, 2013). To alleviate this, their experiences were compared to previous literature. Consequently, I argue that my findings do not always just represent the experiences and views of the population I interviewed but can be applied more widely.

4.7: Ethical considerations

Ethical approval was gained from NU Research Ethics and Governance Committee. At the heart of their ethical principles is the obligation to respect participants' welfare and rights and that research is conducted with the minimum possible risk (NU, n.d, a). From this, three guiding ethical principles were identified, consent, anonymity, and conduct of research.

4.7.1: Consent

To help participants provide informed consent, information sought to be presented in an accessible way. However, additional measures were put into place for victims. All information provided to survivors was checked by GOLD members and changes were made based on their feedback. A few members said they found any forms confusing and would prefer to discuss matters. All participants were therefore provided with written information and offered the opportunity to discuss the study. While feedback from GOLD was invaluable, it is essential to recognise that the older generation are not a homogenised group and may therefore require information in a different format. Consequently, when participants made contact, they were consulted with regarding their preferences. One respondent asked for information on blue paper, in font 14. This was provided. By consulting with GOLD and adjusting documents, the commitment to present the research aims in a clear and open way was adhered to. This facilitates reducing power imbalances between researcher and participant (Bravo-Moreno, 2003). A form to gain informed consent was designed for all sample groups (appendix 6). These were provided in advance of interviews, along with the participant information sheet. Consent was also verbally discussed before each interview.

Pursuant to the Mental Capacity Act (2005) (MCA), it was assumed respondents had capacity to provide consent. Eight survivors were referred by a gatekeeper. It is unlikely that organisations would refer an individual if they believed they lacked capacity or would be likely to suffer unrecoverable emotional trauma. Consequently, gatekeepers acted as a filter, helping determine capacity and ability to cope with the research process. Capacity was additionally assessed by me through conversations with all respondents before the interview. These conversations included discussing the research and its purpose. In doing so, it was possible to ascertain if they were able to give informed consent. If, at any stage, it was suspected that a respondent lacked capacity they would have been informed I could not include them and thanked for their time. When participants made direct contact, capacity was assessed by me through conservations, as detailed above.

While it was assumed respondents had capacity, taking account of possible vulnerabilities extra measures were taken to ensure consent was freely given informed consent. NU (n.d, b) take guidance from the Care Act (2014) (CA) when defining vulnerability and stress the importance of considering whether an adult has care and support needs due to a list of possible vulnerabilities, such as mental health, or a physical or learning disability. Initially I was unaware if respondents had care and support needs. However, older people are more likely to have health issues which result in care and support needs (NHS England, n.d). Consequently, in line with the guidelines given by the Economic and Social Research Council (n.d) on conducting research with potentially vulnerable people, all respondents were given time and opportunity to access support for their decision making, by, for example, discussing it with a friend. They were informed of this option upon first contact and reminded in the participant information sheet. They were also told they could ask questions at any stage, and, following feedback from the ethics application, they were offered the option of meeting me first. If it was unsafe to send participants information, additional time would have been provided before the interview so they could read the information and consent sheet. If after reading this, they wished to discuss it with another, or wanted time to consider participation, the interview would have been rescheduled. If they were accompanied by another person, time would have been given for them to have discussions in private. Alternatively, if there was a safe place documents could be sent to, including by electronic means, this would have been afforded.

Participants (if they wished to receive a copy) were provided with a written report of the analysis and invited to make comments. This approach was utilised by Beck (1999), who examined an emotive area, as interviews were conducted with victims of indecent exposure. He claimed participants benefited from this. Furthermore, inviting participants to comment helps diffuse the power imbalances between the researcher and participant (Karnieli-Miller, 2009). By being able to correct any distortions, it facilitates ensuring their voice is heard over the researchers (Marcus and Fischer, 1986). This is intrinsically linked to how feminist and social constructionists prefer research to be conducted (Shulamit, 1992; Allen, 2004).

4.7.2: Anonymity

Each participant was invited to choose a pseudonym which was used when referring to them. Identifiable information including names of other people, services, and geographical location were anonymised. All data was collected, transported, and stored pursuant to the Data Protection Act (2018) (DPA). For example, by storing data in secure places, shredding transcriptions, and ensuring data was destroyed within three months after the conclusion of the study. In doing so, the legal rights of participants were protected.

4.7.3: Conduct of research

A key concern when researching trauma is the possibility of causing victims distress. However, while some victims become upset during interviews, Ellsberg and colleagues (2001) argue that most still actively choose to proceed, after being given a moment to become calm. Respondents were repeatedly told they could stop or pause the interview, at any stage and monitored throughout the interview process. When telling their stories, if a participant became upset or distressed, they were asked if they would like to stop the interview. Research examining how professionals might suffer trauma when asked to discuss emotive topics is scant, but it is recognised that the retelling of experiences of working with victims can cause distress (Band-Winerstein et al, 2014; Lusk and Terrazas, 2015). Consequently, practitioners were told they could stop interviews at any stage and monitored throughout the interview process. Providing respondents with the option of stopping provides an element of control over the process. This in turn helps reduce power imbalances (Karnieli-Millier et al, 2009). All participants were also given the opportunity to reach an emotional equilibrium before the end of the interview. This was achieved by asking closing questions to give time to *'fade out'* from the interview (Hennick et al, 2013, p. 114). Where possible these questions were based on positive information gained from the initial opening questions. For instance, one participant talked fondly of their grandchildren and their contact with them. They were asked to describe their favourite memory of their grandchildren. When it was not possible to ask detailed closing question(s), respondents were asked to reflect on anything positive. While it is recognised that the topic under investigation may cause distress, it is also worthy to note that research indicates that many survivors wish to be heard and have their story listened to by an

attentive other (Miller, 1996). It has also been observed that abused women tend to regard telling their story as a positive process (Downes et al, 2014).

To reduce the risk of perpetrators knowing victims had made contact, respondents were asked to provide details of how and when it was safe to contact them. No survivors were still in physical contact with perpetrators. Further, to help protect victims, they were provided with information on National support services they could access if the interview or seeing the advert caused them distress. The WHO (2001) recommend this as a method to help minimise risk to participants.

Participants were provided with the choice of where (such as CAB, or university campus) to conduct the interview, and what type of interview (face to face, telephone, or Microsoft Teams). Sturges and Hanrahan (2004) found that participants value choosing the type of interview they would like to take part in. This '*needs to be on their own time and on their own terms.'* (Hlavka et al, 2007, p 914). Hogan (2016) suggests that the flexibility of choosing the location and format may enhance safety for participants. This is particularly important because some survivors could still be in an abusive relationship/situation at the time of interview and may be living with their abuser. Moreover, providing participants choice accords with feminist principles because it arguably reduces the power imbalance between the researcher and participant (Shulamit, 1992). After ethical approval was granted, a respondent asked if they could be interviewed in their home. While the original ethics application did not exclude this option, it was not explicitly covered, and no consideration had been given to lone worker safety measures (NU, n.d, c). Consequently, an amendment was sought and granted. The application drew attention to protecting my safety by not conducting home interviews, if the victim lived with the perpetrator, and by taking reasonable care of myself (Health and Safety at Work Act, 1974). The environment where research takes place can influence the dynamics between participant-researcher (Hockey and Forsey, 2012) and thus alter power dynamics (Rutter, 2020). It shows a level of trust on respondents' part (Moore, 2002) and therefore requires researchers to respect this and respondents' home. Arguably, it facilitates participants feeling more at ease because they are in an environment they can control, with their personal (if they have them) safe keeps. It arguably aligns with the intent to reduce harm to participants and reduce power hierarchies (Shulamit, 1992).

If any adverse events or incidents occurred during the research process, these would have been reported. None occurred in the present study. Notwithstanding this, at the start of each interview, participants were asked questions about themselves. In the first interview with a survivor, one question ‘do you have children’ caused emotional distress because the respondents’ children no longer spoke to her. While respondents were warned they might experience some distress during the main part of the interview, I felt it was unlikely they would have anticipated some from ‘getting to know you’ questions. As such, the question on children was removed to prevent similar incidents. This demonstrates how ethical considerations operated throughout the entirety of the project and changes made, if necessary, to ensure they resonated continually.

To safeguard rights, participants were informed of their right to complain and provided details of how to. This information was provided in the participant information sheet, consent form, debrief sheet, and respondents were also verbally reminded.

Internal ethical standards of organisations were considered. I asked organisations to provide internal research governance policies and ethical standards so I could adhere to these. When conducting research with social services, if four or more departments are contacted, then ideally ethical approval should be sought from Adult Directors of Social Adult Social Services (ADASS, 2021). An application was submitted, and ethical approval was granted with no suggested amendments (see appendix 7). The Salvation Army (SA) asked for an ethics form to be completed. Approval was granted after some minor negotiation. The ethics committee felt the participant information sheet contained too much legal information. I explained the necessity of setting out legal rights, which satisfied them, and the research was advertised in SA centres across the NE of England.

4.8: Establishing validity

Validity refers to the extent that studies are credible (Zumbo and Rupp, 2004). The practice of validation should aim to highlight the hidden biases and assumptions of the researcher (Messick, 1995). Given any criminological research is *‘a social, political and ethical activity’* (Davies and Francis, 2018, p29), it is essential to take a reflexive approach to ascertain the validity of studies (Stanley, 2018). Reflexivity allows researchers to consider how knowledge is produced by providing transparent

reflections of their positionality and personal values (De Souza, 2004). Taking a reflexive stance is thus seen as a way of establishing credibility of studies (Patton, 2002). Further, reflexivity recognises that researchers approach research from different perspectives and are thus never truly neutral (Cook and Fonow, 1990; Guba, 1990; Stanley, 2018). Taking a reflexive approach is thus suitable for my study and is used to reflect on how it establishes credibility, and my possible hidden biases and assumptions. To aid reflexivity a research diary was used. This provided a valuable tool to document and reflect upon my decisions during the research process (Nadin and Cassell, 2006). Before proceeding, it is essential to note that I have, and continue to, refer to myself in the first person because it promotes deeper reflections. As Davies (2012) astutely notes, it:

'(…) forced comparisons between the personal and impersonal which, in turn, have caused me to reflect more deeply on emotive, individual and subjective analyses of personal experiences.' (Davies, 2012, p744).

Also, when I discuss the findings, I often use the present tense to help bring life to the experiences shared with me which reinforces the power of their voice.

4.8.1: Credibility

Credibility establishes the extent the research account is believable and appropriate (Miles and Huberman, 1994). Internal validity is used to determine credibility and depends largely on the procedures of the study and how rigorously it was performed (Zumbo and Rupp, 2004). It is increased through adequate recruitment strategies, sample selection, data collection, and data analysis (Patino and Ferreira, 2018). This chapter has detailed these and justified their use, with the aim of demonstrating their credibility for the present study. Limitations of the method were provided in section 4.6.5. Moreover, by describing the links between the methodology and the elements of my project, I have attempted to provide a cohesive, and detailed account that supports credibility. This is strengthened by presenting an in-depth account of the research findings (supplemented with verbatim quotes), in chapters 5, 6 and 7.

It is recognised that the choice of methodology could be impacted by my experiences, views, and interpretations of the world. I ascribe to feminist principles and believe in social constructionism. However, I have provided justification for the methodological

stance adopted, that is grounded in literature and not personal views. Further, an extract from my research diary shows consideration of other approaches and why these were dismissed:

"Critical realism – participants make sense of drawing meaning from their experiences and the impact of broader social context on such meaning – would allow for participant voice, therefore. Fits well with intersectional! But SC has been recognised as beneficial lens for EA – see Hall.

Intersection? WHY NOT SOMETHING ELSE? Ecological also allows examination of multiple factors and has been used to examine EA – but intersectional not been used b4 so thus adds originality; and feminism known for its emancipatory and bring social justice and links to HR – essential to recognise as aids critical criminology - see Hall!!! & want to introduce social justice aims"

Despite dismissal of other paradigms which were based on objective reasoning, I recognise that the application of the chosen methodology, is, to an extent, value laden. It is impossible to escape the reality that I am influenced by the social, institution and political context I have experienced throughout my life course, but by giving recognition to this, allows for an assessment of validity and has facilitated this reflective account. As Davies and Francis (2018) argue: *'This later aspect is one hallmark of critical social research'* (p.26). Also, within the research findings I have stated and discussed conflicting findings.

4.8.2: Hidden bias and assumptions

To critically reflect on hidden bias and assumptions that may shape the research process, it is essential to step outside one's own standpoint and cultural membership (Braun and Clarke, 2013). As a female, who has experienced different forms of abuse I share some commonalities with survivors. I have also managed large caseloads and supported people with complex needs, who had often experienced different forms of abuse. In this sense, I was an 'insider' because to some extent, I 'belong' to the groups I studied (Sarantakos, 2013). There are recognised benefits of being an 'insider'. Dwyer and Buckle (2009) argue it facilitates the ability to engage respondents and promotes a more sensitive, empathic, and understanding approach. However, it can lead to greater bias or directing the research in a manner that is important to the

researcher (Kanuha, 2000). To mitigate this, the research design, conduct of study, and data analysis all sought to represent participants' voices. Conversely, an ‘outsider’ is seen as being more detached, objective, and may find it harder to access participants (Chawla-Duggan, 2007). I was an outsider when interviewing older survivors, due to the age gap between us. Some younger researchers may have concerns about researching older people, feeling their age will hinder older victims’ willingness to share their experiences. I did not feel this way. I attend a weekly Thai Chi group where I am often the only person under 60 and have built up excellent relationships with many older people. Most weeks I have tea with several older women, and we share stories about our lives and discuss current affairs in the same way I do with younger counterparts. I also volunteer on a project that assists the over 50s to assert their health and social care rights. This role involves discussions about personal needs which are extremely sensitive. As a result, I did not feel nervous about carrying out research on older women. All participants were very willing to speak to me, asked me questions about myself and made comparisons to their own life. Therefore, I do not believe my age acted as a barrier. Nonetheless, I did not assume I would identify with participants. Before each interview, discussions took place with survivors (by telephone) and practitioners (by email) that helped build relationships of trust. To minimise bias, I also reflected upon interviews. The following extract in my diary documents an assumption I initially held in relation to using Microsoft Teams to gain data from survivors and how this was rectified:

‘Interviews – Research shows that virtual provide alternative – can be superior 4 some groups….w/elderly? Mmm not sure – but is this me assuming older lack ability w/technology? Or dislike it? Think CSEW -this is why they excluded & did not look at other ways. O’Keeffe used computer – feasible therefore.

-----To do: offer participants ways 2 interview: inc Teams etc.’

4.8: Chapter summary

This chapter has outlined the methodology adopted in this thesis and highlighted its strengths and weaknesses. Attention was given to the ethical considerations and the reflective approach taken to demonstrate validity was provided. The next three chapters provide a presentation, interpretation, and critical discussion of the research findings. Chapter 5 presents and discusses the findings from the 13 interviews carried

out with older survivors. Chapter 6 and 7 sets out and considers the research findings from the 21 interviews with professionals. Chapter 6 focus on their experiences of supporting older survivors, and Chapter 7 highlights their perspectives of the nature and impact of violence and/or abuse on older victims.

Chapter 5: The voices of older female survivors

5.1: Introduction

This chapter presents the findings from the in-depth interviews with 13 female survivors, who experienced violence and/or abuse (self-defined), since the age of 60. Eight, additionally, discussed experiences prior to turning 60. All 13 respondents self-identified as White British and most classed themselves as having a physical and/or mental disability (n.11). There were variations in their current age, social class, and religion (see appendix 2). Apart from one respondent, all participants lived in the Northeast of England. All discussed their experiences of violence and/or abuse, and all chose a pseudonym. This chapter outlines the experiences of these 13 older women, using their chosen aliases. The first section highlights the types of violence and/or abuse experienced, the second unearths their descriptions of how age and other factors are connected to their experiences, and the third section outlines how the type of perpetrator affected the impacts of violence and/abuse on them, and the services and/or support they sought. The last section discusses the findings and last a chapter summary is provided.

5.2: Types of violence and/or abuse experienced

Numerous types of abuse are evident. As shown in Table 9, a common theme was most survivors (n 11) experienced more than one type of violence and/or abuse, while others (n2) only described one type. When this was in isolation, it is identified as financial abuse. This is somewhat consistent with Mowlam and colleagues (2007), findings that show some respondents experience multiple types of abuse, while others discuss one type, which includes what I have termed non-domestic abuse (NDA). Academic observations highlight that, for ‘adults at risk’, at any age, there is rarely one type of abuse occurring in isolation (Chisnell and Kelly, 2019). Their observations relate to DVA and NDA because they are framed within the safeguarding framework. As such, it seems older survivors, similarly to younger adults, are commonly exposed to more than one type of victimisation. It is also arguable that both age groups can experience DVA and NDA.

Seven respondents experienced domestic violence and abuse (DVA) because they explained an incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse that was committed by either their ex-partner, son, daughter, or sister (Home Office (HO), 2013). It is noteworthy that the Domestic Abuse Act (DAA) 2021 is now in force and coercive control is a crime under the Serious Crime Act (2015). Consequently, some of the experiences discussed are feasibly classified as criminal offences. It is, however, beyond the ambit of this research to examine whether the experiences shared with me, meet the criteria of criminality or the definitions enshrined in these Acts. One of the seven respondents (Korine) who disclosed DVA also described her experiences with the Local authority (LA), and care home staff as abusive. For ease, as noted in chapter 1, when experiences do not meet the definition for DVA, I use the term ‘nondomestic abuse’ (NDA). In total, seven participants described NDA.

Table 9: Summary of survivors’ experiences post 60.

Pseudonym	Type of violence and/or abuse	Perpetrator(s)
Angus	Emotional and coercive control	Sister
Ellen	Financial, age discrimination Emotional Emotional and verbal	Care workers Professionals from social services Neighbour
May	Emotional	Partner (now ex)
Scarlett	Emotional, physical, and coercive control	Son
Ricky	Physical, emotional, and financial	Husband (to be ex)
Linda	Emotional and verbal	Neighbour
Caroline	Neglect Sexual	Care home staff Male resident in a care home

Joan	Emotional and financial	Partner (now ex)
Korine	Financial, verbal and emotional Neglect, emotional and age discrimination	Daughter and both sons Local authority and care home staff
Victoria	Financial	Daughter
Sharron	Emotional	Professionals from social services
Joanne	Emotional	Professionals from social services
Tegan	Emotional	Professionals from social services

There was a mix of DVA and NDA, with no difference between which one is most frequently disclosed (DVA = n.7; NDA = n.7). Korine experienced both DVA and NDA. The three respondents (May, Ricky, Joan) who reported violence and/or abuse by their ex-partner/husband report physical, emotional, and financial abuse. These have been recognised by previous studies examining DV against older women (Lazenbatt, 2013), and DA of older women (McGarry and Simpson, 2010, 2011). However, these studies do not consider abuse committed by adult children. As discussed in section 5.4.1 Scarlett, Korine, and Victoria experienced abuse by their adult children**.** Further, one type of DVA that is worthy of particular focus is coercive control. In general, research only considers how this type of abuse features in heterosexual relationships (Policastro and Finn, 2015; Sprangler and Brandel, 2007, Wydall et al, 2017). As developed below, my findings move beyond this because perpetrators are a son and sister.

5.2.1: Coercive control

Scarlett, who experienced abuse by her adult son, told me about several incidents which may amount to coercive control. She explains how her son frequently used physical abuse and/or damaged her property if she did not give him money and/ or allow him to live with her after he had been in custody (either due to attacks on her or drug offences). Giving just one example, she told me how he *"smashed"* her house up, including breaking windows, pushed her, and was violent:

> *"…..released from prison and have nowhere to go. I couldn't see him on the street so I let him stay but he would get violent, like his dad did, and smash up the house, if I refused to give him money……….He smashed all the kitchen up, broke the windows, pushed me into the stairs and hit me."*

Angus also describes coercive control, but, by her sister. She tells me she regularly used a variety of manipulative and controlling behaviours to gain money from her. This included threatening language, bullying, and verbal abuse. Family mistreatment is reported by Mowlam and colleagues (2007) and includes harassment, threatening behaviour, legal, other disputes, and volatile relationships. However, coercive control, which is now a recognised crime (Serious Crime Act (SCA), 2015, s.76) is not covered, and it is unclear if family members included sisters. Notwithstanding this, it helps ascertain that family members can be perpetrators, and my findings demonstrate this can include sons and sisters, who are possibly committing the crime of coercive control.

Controlling and coercive behaviour is only recognised as a criminal offence in intimate relationships (past or present) or between family members (SCA, s76(2)). It also requires there to be a pattern of behaviour. While I am not suggesting the remit should be widened to include wider relationships, four stories from my research open a valid debate about how acts are arguably perceived as tantamount to coercive control in NDA situations. Ellen, Sharron, Joanne, and Tegan all described the actions of social services as bullying and intimidating which is a form of psychological/emotional abuse (DoH and SC, 2021). They experienced several incidents of this during the process of having their care and support hours reviewed and suggested this behaviour was an attempt to get them to say that they did not require care and support hours. For instance, Ellen said she was bullied and intimidated by social service workers, when

they reviewed her hours for care and support. She describes how they belittled her, accused her of lying, and threatened her with further reductions in hours if she continued to complain. Ellen believes social services were intent on decreasing her hours and inferred that the negative stereotypes associated with ageing and disability were used to convince her that her hours could be reduced. Likewise, Sharron who was *"fighting"* social services believed the treatment towards her stemmed from intents to reduce her care and support hours and linked this to the undervaluing of older people, and individuals with care and support needs. Commenting on this she said:

> *"…they do all they can to get them hours reduced, they don't care about the person underneath and what you can or can't do. So your, well almost, feel like you're bullied, intimidated into saying you're okay, but you're not, but too ashamed and embarrassed to say otherwise….You are no longer a taxpayer. Why should you be getting anything, your no longer putting anything in. So, as an older person you are put out to pasture."*

Explaining one situation with her social worker, who was older than her, Tegan tells me how the social worker used her own older age and notions that older people do not need to eat as much, to try to get her to say she did not need support four times a day, to take her medication:

> *"I have to take medication four times a day and it requires food, but I forget my meds, I forget to eat, so I need help. She said to me, that at our age, she is an older woman as well you see, doesn't have to eat four times a day. I feel like she is trying to control me into saying I shouldn't need to, but I do."*

Joanne says her social worker compared her to an 80-year-old woman, *"who could still walk to the shop".* As Joanne was unable to, and is younger, she found this comment belittling and a ploy to get her to deny she had mobility issues which would lead to a decrease in her care and support hours. Similarly, to the three other participants who discussed potential abuse by social service workers, Joanne believed the undervaluing of older people was a factor contributing to the aim of reducing care and support hours and was adamant it was not because she did not have qualifying care and support needs under the Care Act (2014), s13.

When describing her experiences Tegan uses the words controlling and coercive, saying that because her husband had, among other things, coercively controlled her, she *"could see"* professionals from social services were trying to control her into saying she did not need care and support hours:

> *"Having experienced a controlling and coercive relationship, well that's not all he did, he was very violent, raped me, beat me, belittled me, you name it, but that control, having been there before, I could see the way they were speaking to me and the things they saying were controlling and coercive, trying to control me into saying I didn't need support, I didn't need help."*

While Ellen, Sharron and Joanne do not use the words controlling or coercive, as set out above they arguably convey how they felt controlled into saying they did not have care and support needs. Their experiences arguably amount to a pattern of behaviour because they occurred more than once, with the process of carrying out care reviews ranging from six months to one and a half years.

5.2.2: Non-domestic abuse (NDA)

Seven respondents told me about experiences of NDA, including, as detailed above, emotional, and psychological abuse which was arguably seen as coercive and controlling behaviour. Caroline and Korine describe possible neglect when they were in a care home. Neglect has been recognised as including a failure to provide personal or medical care, ignoring someone (SCIE, 2015), and not being taken care of (NHS, 2021). Caroline, who had been previously placed in a care home, told me that care workers failed to assist her with required daily exercises to help her stay mobile, and how they ignored her, which left her feeling she had been left to "*rot and die*". Korine echoed similar sentiments saying no one engaged with her:

> *….., no one engages with you, it's where you go to rot and die. It's not the staff's fault, they have so many too care for."*

Korine also told me that her experience in the care occurred after she was made homeless and believed she was potentially abused by the Local Authority (LA) prior to this when she sought their help with housing:

> *"I was then officially homeless and in a very vulnerable and threatened state. I'd never been in that position before, never needed to go to the council for anything. And they were very unhelpful and very intimidating. And as an older person who'd just been through all this hassle, I didn't know what to do. When I came out of hospital I was told by a social worker that I was going to [name of care home given]. And I was very frightened by this.*

Korine also told me how she had been discriminated against, saying she would not have been placed in a care home, if she was younger. She believed the LA would have put her in temporary accommodation instead. Potentially this is age discrimination because it seems she experienced unequal treatment based on age (Equality and Human Rights Commission, 2020). However, Korine also disclosed mobility issues, and thus actions of the LA were feasibly driven by this.

Caroline also told me about her experiences of sexual victimisation, committed by a male resident, who she felt was exposing her to inappropriate sexual touching of himself:

> *"I was in a room full of people who have severe dementia, really bad needs. No one talked to me, and the staff, it is not their fault, their busy looking after people who are worse than me. I was all alone. I was left rotting, waiting to die, I just wanted to go home… He sat touching himself under his dressing gown. He was always looking at me, at the same time, I just wanted him to stop, I didn't like it, it scared me."*

Ellen discusses different experiences of NDA, committed by a variety of people. Talking about her experience with domiciliary care workers, one type she relays potentially amounts to discrimination (age and gender), she said:

> *"One of the things that's bugged me a lot is having carers who think because you're older, that you don't know anything and you're stupid and if you get mixed up about something, that's because you're old…It's not necessarily their fault. It has to do with education, and the lack of training from the agencies really, they don't really make people aware of how to be with different people. They don't understand the cultural differences that people have and they can be*

really inappropriate in your home. Because they think you're a stupid old woman."

Most respondents experienced more than one type of victimisation and there is an equal mix of DVA and NDA. Irrespective of the type, all participants reflected on age, albeit in different ways. Furthermore, participants told me about a variety of factors which impacted on their experiences of violence and/or abuse, including dependency, shame, intersectional identities, and past victimisation. These factors, alongside age are set out below.

5.3: Factors that impacted on experiences of violence and/or abuse

5.3.1: Age

All 13 participants mention age when describing their experiences of violence and/or abuse. However, there are variations in how this is interpreted. As previously noted, Korine believes she was discriminated against due to her age. Ellen's narrative above describes potential age and gender discrimination by domiciliary care staff. Discrimination is a form of abuse and includes discrimination on the grounds of age and gender (Department of Health and Social Care (DoH and SC), 2021). The effect of biased social constructions that see older people and those with disabilities as naturally deserving less rights and agency, often result in age and disability discrimination (United Nations (UN), 2019). This can intersect with other inequalities, such as poverty, and women are more affected than men because they are more likely to be poor and/or disabled (Centre for Policy on Ageing, 2016). Korine and Ellen identified as working class, non-affluent and disabled. It is feasible that the combination of age, gender, disability, poverty, and social class placed them at increased risk of abuse. However, it is also possible that individually some of these are risk factors, and not others.

Ellen, Sharron, Joanne, and Tegan inferred that the abuse experienced from social services stemmed from the undervaluing of older people (ageism) and in Ellen's case she also linked it to her gender. All four respondents further told me that the way social services 'used' age, caused them to feel embarrassed that, at their age they had care and support needs. It was implied that notions of ageing and vulnerability had been used as a tool to control them into accepting less care and support hours. Mowlam

and colleagues (2007) acknowledge that some of their participants had *'difficulties in being assessed as in need of social services support'* (p.18) that were '*sometimes presented as a comparable abusive incident in people's accounts'* (p.38), but they do not offer an analysis of how shame, and negative stereotypes could be used as a potential method of control by practitioners in social services. It does, however, seem accepted that feeling ashamed is a recognised emotion that some disabled people experience (Johannsdottir et al, 2021). Further, Brown (2010) suggests that as an emotion, shame causes and reinforces the internalisation of self-hatred and self-loathing. Those impacted pursue modification, suppression, treatment, or medication for their behaviour and/or thoughts. This is arguably reinforced by the way vulnerability is framed and understood in society, and by Government policy and legislative mandates which reinforces the idea that people with care and support needs are inherently vulnerable (Pritchard - Jones, 2018). Depicting people in this way risks them being seen as 'others' who are worthy of pity (Ruof, 2004). To avoid being seen in this way individuals might suppress their needs for care and support. This arguably impacts more on older people because there is an additional desire to reject age-ascribed common perceptions (Biggs et al, 1995). Taking account of Ellen's, Sharron's, Joanne's, and Tegan's voices, it is feasible to suggest that when carrying out care and support reviews, practitioners from social services use shame and stigma with the aim of controlling older women to suppress their needs for care and support.

A different picture emerges when experiences of NDA are committed by either care workers, the LA, or a neighbour. In these situations, participants do not believe age was used as a tool to control them into doing and saying certain things. Linda, who experienced emotional and verbal abuse from her neighbour says it was *"hard to feel safe again"*. Caroline tells me her age caused dependency needs which meant she had to stay in a care home until her husband was able to care for her again. As set out earlier (section 5.2.3), she told me about sexual victimisation and neglect while in a care home. Korine, after feeling intimidated by the LA, did not know what to do, which she attributed to her age:

> *"And as an older person who'd just been through all this hassle, I didn't know what to do."*

Similarly, Mowlam and colleagues (2007) found that their respondents *'did not always know what the appropriate action was to take'* (p.31). However, it is unclear if this relates to DVA, NDA or both, and they do not consider situations where professionals from the LA might be abusive.

Those who disclosed DVA, also do not suggest age was used to control them. Instead, as further explored in section 5.4.1 age caused Scarlett to feel embarrassed that her son had abused her, which initially prevented her from seeking support. Linda, Victoria, and Angus see their age as a factor that hindered recovery. Commenting on this, Angus said:

> *"So the abusive language started so I just put the phone down. I would go to see her if she could just be calm and collected and nice…But I know that's not going to happen. So I'm not going to go anymore because that's just going to stress me. And I'm not going to stress myself because I think as you get older, I think it just takes you longer to get over these things. I think when you're in your 30s or your 40s…you can just shrug it off and think, well, it happens now and again. But as you get older, and you want your life to be peaceful, as peaceful as you can say for another 10 years, I'd like that 10 years to be nice and peaceful and I don't want the hassle from her. And I know if I go up there, I'll get abuse and then her family will join in as well."*

Angus' narrative additionally infers a sense of empowerment because she took control of the situation by putting the phone down on her sister and not going to see her anymore (Ocakli, 2019; Rappaport, 1987). All 13 respondents arguably demonstrate how they are empowered in a variety of ways. The empowerment of older survivors was discussed by some of the DVA practitioners interviewed, and thus a discussion of this will advance in Chapter 7.

May, who experienced DVA, seems to suggest that her age and other factors impacted on whether to leave:

> *"Now because I was in hospital for five weeks and because I'd broken my leg, I was dependent. And it's scary to let that go. At my age, this is where a man gets you really stuck. That's where it really made me think twice. Let me go. Because what if something happens to me? And I'm still struggling dealing with*

that in my present position. I have to make that decision. Are you going to let go of it? Knowing that summat might happen and you're on your own? Yes, I am. I had a conversation I phoned up somebody up at the refuge because I knew what he's gonna do next."

Alongside age, as presented below, several participants discuss multiple factors, and the impact of these.

5.3.2: Generational differences, intersectional identities, dependency, shame, stigma, financial reasons, physical, and/or mental health

Multiple factors seemed to have prevented survivors from seeking support or leaving their relationship. The four participants who experienced NDA by social services (Ellen, Sharron, Joanne, and Tegan) indicate that feelings of shame intersected with their physical and mental health and hindered them from seeking support to challenge decisions made by social services. For instance, Tegan told me that:

'At first I just crumbled and I got sicker and sicker. I was too ill, bullied, ashamed, and too tired to even think about fighting it.'

Shame can cause people with disabilities to suppress their behaviour (Brown, 2019), which when coupled with the effects of biased attitudes that see older people and those with disabilities as naturally deserving less rights and agency (UN, 2019), could feasibly inhibit them from seeking support. When this intersects with other inequalities such as gender, and poverty, it is likely to cause additional barriers. Ellen, Sharron, Joanne, and Tegan identified as working class, non-affluent and disabled. Their experiences arguably infer that gender, disability, poverty, social class, and the inequalities associated with these (either individually, a combination of any of them, or all of them) created issues which initially hindered their help seeking behaviour.

Moreover, all conveyed a sense of losing power which further impacted on them. Commenting on this, Ellen said:

"It actually made me feel really despondent and powerless, Emma. Yeah. Because it was like, well, you can't do anything. You just have no rights.

Likewise, Tegan told me:

> *"It makes you feel like you should be shameful, shameful for having to ask for care, and like, well, like I am needy and powerless."*

This sense of powerlessness echoed in Joanne's and Sharron's stories too, with Sharron saying she did not have the strength to keep *"fighting"* them. It thus seems that the actions of social service services caused them to feel powerless which further seems to have affected their ability to initially challenge practitioners' decisions. Stevens (2017) who is a long-term service draws stark attention to how many users do not have the *"knowledge, experience or weaponry to fight the system and win".* The stories of I share seem emphasis this and additionally show how shame intersects.

Respondents who describe DVA speak about different issues, but these mainly relate to what prevented them from leaving their relationships. For example, Ricky believed it was her *"duty"* to remain with her violent husband because she had been *"married for a long time".* Blood (2004) and SafeLives (2016) suggest that because of generational differences, many women felt it was their duty to remain married to their husbands. Furthermore, generational differences are likely to cause older women to experience shame and stigma which prevents them from making disclosure (Zink et al, 2006). Ricky reflected on how she felt *'deeply ashamed'* which was a factor preventing her from making disclosure. It is feasible this sense of shame is linked to generational differences, because prior to the 1970s, it was socially unacceptable to disclose issues that happened behind closed doors (SafeLives, 2016).

Due to generational differences, it has been suggested that older women are less likely to identify their situation as DA (Scott et al, 2004). However, Ricky told me that her age did not prevent her from knowing she was being abused because she is from *"a long line of strong women"* and was able to make some decisions in her relationship. Ricky further told me that her husband was abusive prior to her turning 60. He continually belittled her in front of others and took control of all the finances. After he retired, he started to become extremely violent. This accords with O'Keeffe and colleagues (2007) findings which indicate interpersonal violence (IPV) is commonly committed by those aged 65 and over, who tend to be retired, whereas financial abuse

is usually perpetrated by 16 – 44-year-olds, who are usually in paid work. Moreover, Hightower and colleagues (2006) found that in some instances retirement increased controlling behaviour by husbands.

Moving beyond the findings and analysis in these previous studies, Ricky reports she was from an affluent background. Unlike many women of her generation, Ricky is also educated. Arguably, the combination of affluence and education provided her with the power to make some decisions in her relationship. Intersectional feminism recognises that all individuals can simultaneously experience both privilege and oppression (Yuval-Davis, 2006). Brah (1991) highlighted this point by illustrating her status as a British Asian woman. Brah was subjected to racism, but as a member of a dominant caste in her community, she held a position of power in compassion to lower caste women. It seems Ricky, similarly to Brah, was able to yield some power due to her affluent and educated position. Nevertheless, despite her relative position of power, Ricky was still subjected to victimisation throughout her life course, which increased in intensity after her husband retired. The dominant social construction of masculinity is linked to violence, as often at the core of masculine gendering is the demand that male-identifying people must achieve and continually re-achieve their manhood (Heilman and Barker, 2018). To ensure he maintained power and control, Ricky's husband initially used emotional abuse (putting her down and humiliating her in front of others) and controlled all the finances. After he started to lose power in society, he exerted more control by also using physical violence. In doing so, he was arguably trying to regain a sense of power and re-achieve his manhood.

Alongside generational differences and intersecting identities, Ricky was affected by other factors which impacted on her willingness to seek support and leave her relationship. She told me that she believed her husband had Alzheimer's because he had been wrongly diagnosed, and how this had, alongside her "*duty*", prevented her from leaving. Older women staying in abusive situations because their partner has dependency needs has been recognised in a USA study (Zink et al, 2003), and Scott and colleagues (2004) found a link between this and traditional views about marriage and gender. After Ricky discovered her husband did not have Alzheimer's, she refused to leave her home, and felt too ashamed to disclose her situation or seek support due to living in a village that has *"village mentality"*. There are concerns about how victims are isolated and controlled in rural environments (CrimeSoppers, n.d). A

recent UK survey indicates that traditional patriarchal attitudes, which facilitate controlling and subjugating women, alongside the isolation of the countryside, prevent women from making disclosure of DA (National Rural Crime Network (NRCN), 2019). The study further demonstrates that older women are less likely to approach support services compared to younger groups. I suggest that Ricky's reluctance to leave her abusive relationship was linked to generational differences, unwillingness to leave her home and fear of going against the established patriarchal norms in her village in case people thought badly of her.

Other respondents who disclosed DVA seemed to have experienced a variety of intersecting barriers, preventing them from leaving relationships, or disclosing their situation. Victoria, Korine, and Scarlett said they were reluctant to disclose their abuse because they felt embarrassed that people might think they were unfit parents. Notwithstanding this, for Korine and Victoria their ill health at the time the abuse took place also seems to have impacted on them. Korine told me about a mixture of financial, verbal, and emotional abuse committed by her children (see section 5.4.1). Some occurred when she was in hospital with a broken hip. She has other health issues, including mental health difficulties. Victoria told me that her daughter financially abused her when she was undergoing treatment for cancer and had depression. At the time she lived with her due to her ill health. Both Korine and Victoria had health issues when their abuse took place. It seems their children took advantage of their vulnerable position by asserting their younger and healthier status over them, thus abusing their more powerful position.

Their ill health initially prevented them from doing anything about the abuse. Talking about this, Victoria said she was aware of the abuse for some time but waited until she was in remission before telling her daughter to leave. It seems her need for care rendered her dependent on her daughter. Supporting this assertion to some extent, Blood (2004), and Zink (2005) suggest that older victims may be reticent to remove themselves from abusers who provide their main care, albeit similarly to EA studies (Adib et al, 2019), these conclusions are confined to partners. It seems Victoria understood that reporting the abuse could lead to the removal of her daughter which could have left her dependent on somebody else for care. This can cause humiliation. Dow and colleagues (2019) found that older victims experience embarrassment because they require help with daily tasks when their abusive adult child is removed.

Building on this, Victoria's story suggests that shame, self-blame, illness, mental wellbeing, and dependency hinders older victims from escaping abuse by their adult children. I return to discuss self-blame in section 5.4.2. Korine, on the other hand, was reliant on her children financially and needed their support to stay in her home. This alongside her physical and mental health issues, shame, and self-blame, seems to have placed her at greater risk and hindered her ability to seek support. When Korine did finally contact the LA, she arguably experienced further abuse (see section 5.2.3).

Feeling dependent was also evident in May's story. May (see section 5.3.1) disclosed she was dependent on her partner due to her health and believed no one else would take care of her. A USA study found that older women remain in abusive relationships due to health conditions which render them dependent on their abusers (Zink et al, 2003). Alongside dependency, May's age, feeling trapped, and fear of being alone intersected, hindering her ability to leave. Knight and Hester (2016) suggest that older women tend to have been in abusive relationships since they were younger. Consequently, they experience an increased sense of feeling trapped. Blood (2004) previously argued this leads to greater practical and emotional issues in rebuilding independent living skills and self-confidence. Nevertheless, in May's situation her relationship started when she was about 63, she left after about two years (65) and was 67 at the time of interview. This finding could tentatively suggest that feeling trapped and having greater difficulty in gaining independence may be linked to age, and/or dependency.

Similarly, Joan expresses various barriers that prevented her from leaving, including losing her home, financial reasons, placement in a refuge prior to turning 60, and her experiences of DVA when she was younger. Commenting on these, Joan said:

> *"When I left [perpetrator name from younger years] we were put into a refuge myself and my two kids and I didn't, I would never go back to another one…..*
>
> *Financial reasons kept us [recent perpetrator] in the same house. I couldn't, well I didn't want to move because I like my house. He couldn't afford to move out at the time because he was starting his own business. So the best thing was how we were living….*

People would say, well, why don't you get out of it? And why don't you do this? And I'll say, because, you know, I'm not losing my home again, and because they don't know what I went through with the first husband. You know, and I didn't want people saying to me, well just give all this up and go, you know, it wasn't as easy as that".

As discussed below, past victimisation and how it impacted on current experiences was disclosed by eight participants.

5.3.3: Experiences prior to turning 60

Eight respondents disclosed violence and/or abuse prior to turning 60. Table 10 below, presents their data.

Table 10: Summary of survivors' experiences pre-60.

Pseudonym	**Types of previous violence and/or abuse**	**Perpetrator(s)**
Angus	DVA (all types)	Ex-husband
Ellen	DVA (all types)	Ex-husband
May	DVA (emotional and physical)	Ex husband
Scarlett	DVA (emotional and physical)	Husband – died
Ricky	DVA (financial, control and emotional)	Husband (to be ex)
Linda	DVA (emotional and physical)	Husband – died
Joan	DVA (control, emotional; and physical)	Ex – husband
Tegan	DVA (sexual - including rape), control, emotional and physical	Ex - husband

All previous experiences were committed by respondents' spouses at the time (n8). Hightower and colleagues (2006) found that older women often describe abuse by husbands over the course of decades with an increase in controlling behaviours after

their husbands retired. Ricky's experiences were committed by the same perpetrator throughout her life course, and likewise to Hightower and colleagues (2006) data, my findings show an escalation in abuse after her husband retired. An analysis of this was reflected upon previously. Conversely, commenting on her unpublished research findings, Bows (2015) argues that the severity of physical abuse often declines as both the victim and perpetrator age, and instead the threat of violence and emotional abuse is enough to intimidate and manipulate survivors. Likewise, to this previous research, Joan and May said their previous partners were extremely violent and emotionally abusive. They describe their recent situations as emotionally abusive. However, their latest abuse was not a continuum of victimisation at the hands of their past partners because it was committed by a different perpetrator. Their experiences can therefore be seen as poly-victimisation, which is a common problem in later life (Ramsey-Klawsnik and Heisler, 2014). Thus, the voices of Joan and May arguably help cast further light on abuse by sequential partners for older women.

Out of the eight participants that told me about past victimisation, seven respondents report that their recent situation was committed by a different person. Findings from beyond the UK indicate a high number of older and younger survivors are abused by someone else previously (Ramsey-Klawsnik and Heisler, 2014; Wilke and Vinton, 2005). In the UK, it seems recognition is only given to how previous experiences and current situations compare, when it is the same perpetrator (Penhale, 2008; Bows, 2015). Observations and findings also seem constrained to DVA. Out of the eight participants disclosing past abuse, four (Angus, May, Scarlett, Ricky,) recently experienced DVA, while four (Ellen, Linda, Joan, Tegan) describe recent NDA. The findings thus highlight how victimisation can be a continuum of abuse, but not necessarily at the hands of the same perpetrator, and it can be either DVA or NDA that is experienced in later life, after experiencing DVA in younger years. However, there are variations in how this impacted on them. For instance, alongside financial reasons and a reluctance to leave her home, when discussing reasons for not leaving her current relationship, Joan speaks about her previous experiences of DVA, how she escaped to a refuge and would never go back to one for a variety of reasons:

> *"I didn't feel like I was a person there. It was a nightmare, my kids hated it, you know, it just weren't nice, weren't a nice experience to, that there was, we have this little room - and there was just no room to swing a cat, and there was, I just*

did not feel - I don't know, I just did not feel….I think because I'd lost my independence, I'd lost my home, I had nothing, all I had was the clothes I walked out – well, what the police took, that's all I had, nothing."

Angus tells me she was abused by her husband when she was younger and this helped her recognise that her sister was controlling, manipulative and abusive. Similarly, as set out in section 5.2.1 Tegan believed her previous experiences enabled her to identify her current situation as tantamount to coercive control.

Conversely, Linda, who describes victimisation by her husband prior to turning 60, spoke about how she knew what to expect and could prepare for his actions. She compared this to her latest abuse. She told me she did not know what was coming because it was committed by her neighbour. Their acts left her so scared that she no longer leaves her house alone, in the evening anymore. The shock of experiencing an unpredictable form of abuse seems to have exacerbated the negative impacts on her. Mowlam and colleagues (2007) report similar findings. Likewise, Scarlett said her past experiences could not have prepared her for the continued abuse her adult son subjected her to:

"I was devastated, totally devastated, I mean – it's your son. I know my husband was my husband but before that he was a stranger, you know this is somebody you look after when they're little, you breastfeed them – I'm getting quite emotional now about that. Do you know what I mean though? It's your son, it's different."

Additionally, Scarlett's narrative arguably demonstrates that abuse is processed differently depending on who the perpetrator is.

5.4: Types of perpetrators and how this affected survivors

As shown in Table 9 (section 5.2), survivors experienced abuse by a variety of perpetrators and three identified more than one. One type of perpetrator that is worthy of particular focus is adult children.

5.4.1: Abuse by adult children

Scarlett's experiences of coercive control by her adult son were set out in section 5.2.1. Victoria told me that her daughter financially abused her when she was undergoing treatment for cancer:

> *"It was small at first, you know the odd £10 here and then, but she got clever, I think she realised I was too sick to really do anything, and before I knew it…well it was thousands in the end."*

Telling me about a mix of financial, verbal, and emotional abuse, committed by her adult children Korine said:

> *"….I got into a bit of financial difficulty paying the mortgage…And so my older son being in a very, very good position financially said that he would pay for the house or even buy it, that would release me of the mortgage and I could live in my house til I died or decided I wanted to move or whatever. Well after about three years, I fell and very badly damaged my hip and various things. I was in hospital and my three children came to me with a letter telling me I had to get out of the house and move into an old people's home. And it was horrific because I knew I was in no physical or mental position to pack up a home. And I was confused because [perpetrator name] was going back on what he'd said. And then he's threatened to put all my, the contents of this four bedroom beautiful house, on the drive and just let people take what they wanted…..He said that he was going to get the gypsies to murder me in the gutter and all sorts of horrible things. I was terrified.*

Mowlam and colleagues (2007) report some abusive situations by children, stepchildren, and foster children. However, there is no analysis of this, and it is unclear if they were adolescents or adult children. Similarly, with the exception of one example of a serious assault against an older woman by her adult son, Nguyen Phan's (2021) findings are not clear if the abuse was child to parent (CTP), or adult child to parent (ACTP). Victoria, Korine, and Scarlett said they were reluctant to disclose their abuse because they felt embarrassed that people might think they were unfit parents. Research conducted in Australia found a link between stigma, shame and embarrassment, and EA, when it is committed by adult children (Dow et al, 2019).

Their findings relate to the response participants received after disclosing their abuse. Alternately, for Scarlett, Victoria, and Korine their sense of shame prevented them from making disclosure which may be linked to their age and generational differences. Smith (2020) argues that older mums are impacted by the internalised mandate of being a 'good mum' and experience guilt when this ideology is not met. Myths and deeply held beliefs that families provide warm, nurturing environments have been constructed over time (Penhale, 1999; Smith, 2020). The traditional patriarchal system helps sustain and recreate these social constructions (Kurz, 1989). The idea of children being violent to their mothers challenges the idealised view of families (Smith, 2002). It is arguably harder for older women to admit they do not conform to these social norms because as discussed in Chapter 3, they were socialised with traditional values and attitudes regarding gender roles, marriage, and family (Straka and Montminy, 2006), alongside a keen sense of privacy about family matters (Wydall, 2017). In turn, this causes a reluctance to seek support for fear of being judged by others. Scarlett, Victoria, and Korine all mention their age and how this caused them to feel embarrassed that their children had abused them. They suggest age made this worse because society expects older women to automatically get mothering 'right'. Consequently, it seems shame, age, generational differences, socially constructed ideas about family and motherhood, prevented Scarlett, Victoria, and Korine from disclosing their abuse for fear of being stigmatised, for being a bad mum. Further, it is tentatively suggested that while shame is experienced by older and younger victims, when their child is the abuser, for older survivors this is more acute. This is because they are more likely to believe they are going against the traditional, socially constructed notion that families provide a place of love and care (Smith, 2020).

When discussing the impacts of abuse by their adult children, there was similarity between the three respondents, but these seemed to differ from how the other survivors discussed their experiences (post 60) differently. The different ways the impacts were vocalised, depending on the perpetrator are explored in the next section.

5.4.2: Impact of **violence and/or abuse**

The three participants (Scarlett, Korine, Victoria) who experienced violence and/or abuse by their adult children all express similar emotive impacts. Scarlett, (see quote above, in section 5.3.3) and Korine said they were devastated. Victoria was heartbroken.

> *"I was devastated. Absolutely devastated. I felt like my world had fallen through."* (Korine)

> *"I was heartbroken. This can't be my daughter, the person I breastfeed, the person I cared for."* (Victoria)

Additionally, they make similar comments about the care provided to their children, and how they breastfed them, and nurtured them. However, as set out earlier (section 5.5.3) when describing the abuse by her adult son, Scarlett drew attention to the difference between her violent husband and the abusive acts of her son, explaining that her husband was a stranger before she met him, while her son was somebody she looked after when he was little and breastfed.

In comparison, Angus who was abused by her sister said it did *"upset"* her:

> *"I'm not saying it does not upset me now and again because it does."*

While this demonstrates an emotional impact, it is arguably not as intense. May, and Ricky who experienced DVA by their partners are somewhat factual when describing the impacts on them. For instance, Ricky tells me:

> *"That was when he beat me and beat me up so badly, I was at the hospital for I think it was 11 or 12 hours or something. I had to have lots of x-rays and things like that."*

While it is not suggested these respondents did not experience emotional harm, it seems they vocalise the impacts differently. Moreover, the three respondents who told me about abuse by their adult children seem to have been additionally impacted by the internal mandate of being a good mum, and shame and stigma for not living up to this ideal. The findings thus seem to suggest that when abuse is committed by adult children, the impacts are different to when it is perpetrated by a partner. Supporting

this contention to some extent, Solace Women's Aid (SWA), (2016) found that the dynamics of offspring abuse are somewhat different from partner abuse. It was concluded that the bond and love between parent and child is different, and the complexities of shame and guilt came to the forefront as mothers believe their parenting skills are under scrutiny. Likewise, Nguyen Phan (2021) findings highlight how the internal mandate of being a 'good' mum caused mothers shame when '*their now adult children'* (p.51) committed abuse. It thus seems that irrespective of when abuse by children takes place, it affects how victims express the impact on them due to additional shame related to being a 'bad' mother. As set out in Chapter 7, professionals discuss their observations of older women experiencing acute emotional impacts when perpetrators are adult children. This further helps support the contention that when older women suffer abuse from their adult children, they vocalise additional emotional impacts in comparison to older victims abused by their partners.

When NDA is committed by practitioners from social services or by a care works, descriptions arguably convey impacts more associated with social harms, as they relate to breaching rights and losing power (Hillyard and Tombs, 2004). As set out in section 5.3.1 a sense of powerlessness reverberated in Ellen's, Tegan's, Sharron's, and Joanne's stories. They thought their rights were breached and they lost power, which caused them to think they brought no value to society. Alongside 'social harms', Ellen, Sharron, Joanne, and Tegan, told me about impacts which are recognised as affecting DVA victims, including a lack of confidence, loss of identity, loss of dignity, depression, and shame (Waldropt and Resick, 2004). Regarding shame, McKie (2005) argues that women believe they are responsible to others. This sense of responsibility has been partially constructed and supported by families and communities. When women believe they have failed to uphold socially constructed responsibilities, it evokes a sense of shame (Crawford et al, 2009). This includes feeling embarrassed for failing in personal relationships with partners. In relation to shame, this is arguably intensified for women with care and support needs because feelings of embarrassment are a recognised emotion some disabled people experience (Johannsdottir et al, 2021). Due to negative conceptions associated with ageing and vulnerability (Jones et al, 2006), this is feasibly enhanced for older women. Ellen, Sharron, Joanne, Tegan, all self-identified as disabled, older women. Arguably, their sense of shame was therefore intensified. My findings show that victimisation

committed by professionals has similar impacts when compared to the consequences for DVA survivors, but shame is arguably increased for older disabled women experiencing NDA.

The type of perpetrator affected who participants assign blame to. When discussing the treatment by care workers (both domiciliary and in care homes), respondents think it was not necessarily care staffs' *"fault".* Two social workers somewhat mirror this view. As such, a discussion of this will be presented in Chapter 7. The attribution of 'fault' and/or blame was apparent in several other narratives. All four respondents (Ellen, Sharron, Joanne, Tegan) who identify professionals from social services as perpetrators, blame systematic and organisational issues. They believe their treatment by professionals from social services stemmed from a need to ensure care and support hours were reduced. Their narratives link this to austerity measures and the undervaluing of individuals with care and support needs, particularly older women. The impact of 'cuts', and the ideology of neoliberalism was discussed in Chapter 2. My findings arguably support academic observations that due to austerity, and neoliberalism, a discourse is propagated around the need to save money, whereby the reduction of care and support packages becomes legitimised (Chisnell and Kelly, 2019). Social workers are told they must cut care packages and feel pressured to act in the interests of protecting the 'public purse'. Ellen, Sharron, Joanne, Tegan also attributes blame to negative social constructs that see older people and those with care and support needs as non-contributors, and burdens to society (Jones et al, 2006; Palmore, 2004; Pritchard-Jones, 2016), who are naturally undeserving of rights (United Nations (UN), 2019). Ageism is so entrenched and accepted that social workers may class their work with older people as mundane and not real social work (Hugman, 2000; Willis, 2016). As contended in Chapter 2, the rhetoric of neoliberalism reinforces ageism (Ward et al, 20020). This alongside the desire to save public money, could inevitably impact on how they respond to older people. My findings tentatively suggest that the combination of ageism, undervaluing people with support needs, alongside austerity and neoliberal ideology, promotes and creates an environment for abuse against older women. Social workers arguably abuse their more powerful position and exert control over individuals, with the aim of meeting obligations to curb public spending.

When abuse was committed by adult children, respondents blamed themselves. For example:

> *'I thought people thought she couldn't have been a good mother because her son was doing that….You think what have I done wrong, where did I go wrong, what have I done that he turned out like this you know?* (Scarlett)

Victoria, and Korine echo similar sentiments, with Victoria saying:

> *"I kept thinking, I must have brought her up wrong, it must be me."*

The limited child to parent (CTP) literature indicates that 'bad parent' discourses are commonplace in society (Edenborough, 2008) and have been infused in a history of neoliberal policy initiatives since the 1990s (Crossley, 2018; Jensen, 2018). Consequently, parents have been constructed as the ones to blame for CTP. Shame and guilt are experienced by older women when they are abused by their adult children because they feel their parenting skills are under scrutiny (SWA, 2016). They blame themselves and believe others will blame them too (Smith, 2015). In turn, this hinders their willingness to make disclosure. My findings support these previous observations, but by placing lived experiences in a gendered maternal context and showing the complex laying of age and socio-cultural expectations about families, I add to this and support Nguyen Phan (2021) unpublished findings, albeit specifically for older women. Although my research is focused on older women, by supporting Nguyen Phan (2021) findings, I also help strengthen her claims that CTP and ACTP have comparable impacts. Moreover, this helps establish that there is no use in calling older women's experiences elder abuse, because it seems that irrespective of age, abuse by children is experienced in similar ways.

Conversely, when DVA is committed by ex-partners, participants blame the perpetrator. When doing so, they sometimes disclose issues the perpetrator had, such alcoholism, but without seeming to excuse their behaviour. Many victims of DVA blame themselves for a variety of reasons and often excuse their partner's behaviour (Broxtowe Women's Project, 2020). However, this was not an apparent finding in the present study as there is no attempt to excuse perpetrators behaviour(s). For instance, Ricky discusses her husband's loss of power in society:

'The less important he became in life, in his work and his position, the less important he became, the more bullying he became to me'.

My findings thus tentatively suggest self-blame might be experienced and/or vocalised differently in older age.

5.4.3: Services and/or support networks

All 13 participants gained formal and/or informal support, which varied depending on who the perpetrator is (see Table 11 below). When it was committed by practitioners from social services, the LA, and care workers, respondents accessed local independent advice services to gain information, advice, and advocacy. In the main, when ex partners were perpetrator(s), support was gained through DVA services and/or friends. Angus, Linda, and Korine also sought support from their friends. Mobilising social and formal support mechanisms arguably shows empowerment (O'Ocakli, 2019), which I return to in Chapter 7. As shown in Table 11 below, some immediately sought help, and others waited. Angus, Linda, Caroline, and Joan all sought informal support immediately. Ellen, May, Korine, Sharon, Joanne, and Tegan waited for different amounts of years. Ricky (who was emotionally and financially abused for many years) gained support after police involvement. Scarlett agreed to DVA support after her son went to prison, and Victoria waited until her daughter had moved out. The factor(s) which prevented them from leaving their relationships and/or seeking support were examined in section 5.3.

Table 11: Types of perpetrators and summary of support sought.

Pseudonym	Perpetrator	Support sought	When sought
Angus	Sister	Friends Church	Immediately
Ellen	Domiciliary care workers, neighbours, and Professional(s) from social services	Local charity for people with disabilities and a local independent advocacy service	After about 3 years
May	Partner (now ex)	Accessed a refuge and after utilised outreach DVA services	After about 2 years

Scarlett	Son	Outreach DVA services	After her son was put in prison
Ricky	Husband (to be ex)	Outreach DVA services	After police intervention
Linda	Neighbour	Friends	Immediately
Caroline	Care home staff, and male resident in a care home	Partner	Immediately
Joan	Partner (now ex)	Friends Spiritual world	Immediately
Korine	Daughter, and both sons LA and care home	Friend Local independent advocacy service	Unsure 4 years
Victoria	Daughter	Family	After her daughter moved out
Sharron	Professionals from social services	Local independent advocacy service Church	2 years
Joanne	Professionals from social services	Local independent advocacy service Care worker	3 years
Tegan	Professionals from social services	Local independent advocacy service	2 and half years

The types of support accessed varies depending on who the perpetrator is. Korine, Ellen, Sharron, Joanne, and Tegan, who experienced NDA all sought support from local voluntary groups who provided information, advice, and advocacy. While these services helped them practically, their remit did not include emotional support to help them come to terms with how they were treated by practitioners. For instance:

> *"They helped me gain care hours back, but it doesn't give me back the two years I lost, it doesn't stop the trauma they put me through."* (Tegan)

> *"Her look, those words when telling me what care I did and did not need, like my feet, cause I have diabetes, she made it seem like getting these done was a luxury, going to spa. (…) My care worker is amazing, I have some support now, but her comments and the way she treated me, still upsets me. I have*

never asked for much, so to be made to feel needy, I felt like a burden." (Sharron)

They do not expect these services to offer emotional support, but this left them to try to deal with the emotional impact alone. While they all have social support networks, there was a reluctance to gain emotional support through social networks as this meant disclosing care and support needs which led to shame. It seems many people with care and support needs experience a sense of shame for being disabled, and judged as inadequate and flawed (Climaco, 2020, Johannsdottir et al, 2021). These emotions are plausibly reinforced by the negative conceptions of ageing and vulnerability (Jones et al, 2006). Consequently, the voices of survivors suggests that the negative stereotypes associated with age and disability prevent disclosure of NDA due to fear of being judged as insufficient and imperfect.

When accessing DVA services, which are designed to offer practical and emotional support (Refuge, n.d), the way experiences are reflected upon is different. For example, May, who accessed a refuge describes it as special and reflects on how their support enabled her to move forward and feel positive:

> *"….how lucky I was I found this one. And the magic that's there. It was like - oh, they're so special. I can't put my finger on the right words, but it was. It was like it's blessed with an awful lot of stuff that place….I'm gonna take some mince pies there this Christmas and you know I'll be catching them up with what I've been doing, it'll be positive things and that. I can let them see I'm coming out of it and shining a bit and that and I'm feeling in a very positive way about that."*

DVA services are specifically designed to offer practical and emotional support (Refuge, n.d). However, as discussed in Chapter 3, DVA organisations are not always suitable for older survivors (Scott et al, 2004; SafeLives, 2016). The findings in my research indicate the contrary because May, Ricky, and Scarlett provided positive feedback on DVA services. However, they mainly accessed outreach services where issues relating to noisy children (Blood, 2004), and a lack of amenities for those with ageing and older life health issues or physical or cognitive issues (Carthy and Taylor, 2018) seem irrelevant. The one survivor (May) that stayed in a refuge, as above,

describes her experience as *"magical"* and was unphased by noisy children. Further, she did not disclose care and support needs.

Joan, who similarly to May experienced abuse by her partner, sought informal support by talking to friends, including the spirit of a friend who died. Likewise, to May, Joan arguably articulates how support enabled her to cope emotionally, she said:

> *"Yeah, I mean, I used to talk to [friend] and I had my spiritual path as well. I have somebody in the spirit realm I lost 40 odd years ago, well, nearly 50 years ago…. I think he's kept me sane, to be fair, because he was a very sensible…..I'd sit in the toilet and lock the door and beg him just to give me some kind of, I don't know, guidance, I suppose. But yeah. So yeah, he did keep me sane. And all the time then when I was poorly in hospital on the drink and stuff like that. He kept me you know...kept me sane."*

Nevertheless, in contrast to May, Joan refused to access a refuge. Her reasons relate to her insistence to remain in her home, and her experiences in a refuge when she was younger, where she felt she lost her independence. Instead, as set out above, she sought informal support through friends, and a friend in the spiritual world. Ricky, Angus, Linda, Caroline, and Korine also sought support from their friends and/or family. Carlson (2002), and Davis (2002) findings suggest that relationships with others and social support can buffer the adverse effects of the emotional impact of DA for younger women. My findings demonstrate that informal support is also beneficial for older victims. Linda, Caroline experienced NDA, and thus it is suggested that informal support is vital for victims of NDA.

5.5: Discussion

This section discusses the findings, and when possible, makes comparisons with previous studies. Likewise, to Mowlam and colleagues (2007) most respondents (n 11) experienced more than one type of violence and/or abuse. However, the findings move beyond descriptions given in this past research because they offer a rich account of survivors' voices, which included their experiences of DVA and NDA. Moreover, one type of DVA, coercive control is arguably thrown into sharp focus. Studies examining coercive control often concentrate on heterosexual relations only,

and official statistics do not disaggregate any types of abuse by family members from abuse by other perpetrators (Ingram, 2016; Policastro and Finn, 2015; Sprangler and Brandel, 2007, Wydall et al, 2017). Although family mistreatment is reported by Mowlam and colleagues (2007) their findings do not reflect on coercive control, and it is unclear if family members included sisters'. Consequently, very little is known about how coercive control features in abusive situations when family members are the perpetrators (Wydall et al, 2017). By highlighting how a son and sister might coercively control older women, my findings help to start unpicking how this type of abuse manifests in family relationships for older women.

Experiences of NDA has also been brought to the forefront which included two accounts of abuse in care homes. Likewise, to a study that listened to the voices of older victims in Sweden (albeit in a hospital clinic and not a care home) (Ludvigsson et al, 2022), respondents described experiencing neglect. When discussing their treatment, both Korine and Caroline said it was not the fault of care staff because they were busy or had so many to care for. In Ludvigsson and colleagues (2022) study some forms of neglect, namely insufficient assistance with buying food or medication was attributed to staff shortages. A discussion of this proceeds in Chapter 7, because two social workers somewhat mirror this view. However, it is worthy to note now that this seems to suggest there is recognition by both victims and professionals that issues in residential settings are due to staffing shortages.

NDA also included abuse committed in the community and four stories in my research showcase how professionals from social services were seen as perpetrators. Tegan, Ellen, Sharron, and Joanne articulate how social workers used negative views associated with ageing, and disability, which were seemingly used to make them suppress their needs for care and support hours. An analysis of their stories suggests that these acts were seen as tantamount to coercive control. While it is not suggested that the crime of coercive control should be widened to include NDA, my findings are worthy of further exploration to further assess how actions of social workers can leave people feeling controlled into suppressing their care and support needs. An analysis of stories also highlights how the four participants who disclosed abuse by social workers blamed systematic and organisational issues. Academic observations suggest that due austerity, and neoliberalism a discourse is propagated around the need to save money, whereby the reduction of care and support packages becomes

legitimised (Chisnell and Kelly, 2019). Building on this, my findings infer these factors combine with ageism, and the undervaluing people with support needs. In turn, this leads to social workers arguably asserting their more powerful positions over older women with disabilities, with the aim of controlling them into saying they do not have care and support needs. In doing so, money is saved, and thus they meet their obligations to curb public spending.

Listening to survivors' stories demonstrates a range of issues and factors connected to experiences of DVA and NDA. These include age, generational differences, established patriarchal norms, shame, physical disabilities, mental health difficulties, ill health, dependency on perpetrators, perpetrators dependency, fear of being alone, fear of letting go, finances, not wanting to lose their home, living in a village, and experiences of abuse prior to turning 60. Age was sometimes an element of the abuse itself. This is demonstrated when discussing age discrimination, or how negative notions of ageing and vulnerability were used as a method of control. It is suggested that in these situations, age, gender, disability, poverty, and social class either individually, or a combination of all of them or some of them, place individuals at increased risk of victimisation. Further, it seems that a wide range of factors often combine and affect help seeking behaviour (for both DVA and NDA) or leaving relationships (only DVA). For example, the combination of affluence and education provided Ricky with some power, and this, alongside other factors, affected her decision to remain in a risky relationship. This included not wanting to leave her home. Joan also expresses this barrier and a range of other features. Ricky and Joan stories thus showcase an extremely complex web of reasons which influenced their decision making. However, the narratives of the 11 older women I interviewed suggest that various factors intersect and create barriers to leaving and/or help seeking behaviour.

Likewise, to previous research (Mowlam et al, 2007), my findings indicate that older survivors are at risk from an array of perpetrators. This included partners, adult children, a sister, professionals, and neighbours. They additionally show how sometimes a risk is posed by more than one perpetrator at once. Moving beyond previous findings however, I offer a richer account of their experiences by giving life to their voices and showing how their experiences differed depending on who the perpetrator was. Similarly, to observations by SWA (2016) and unpublished findings by Nguyen Phan (2021), it is suggested that when adult children are perpetrators,

older survivors experience additional shame and guilt because they believe they are failing to meet socially constructed notions that families provide love and warmth. This causes self-blame and shame, which initially prevents them from seeking support. Further the emotional impacts are vocalised differently, when compared to older survivors who are abused by their partners. I argue that the complex laying of gender, age, and socio-cultural expectations about families, shape their experiences and responses. As set out in Chapter 7, professionals discuss their observations of older women experiencing acute emotional impacts when perpetrators are adult children. This further helps support the contention that when older women suffer abuse from their adult children, they vocalise additional emotional impacts in comparison to older victims abused by their partners.

The type of perpetrator also impacted on what services and/or support networks were accessed. When abuse is committed by practitioners from social services, the LA, and domiciliary care workers, respondents accessed local voluntary groups. It was found that while these services helped them practically, their remit did not support them with emotional trauma, and they felt too embarrassed to seek this support through their social networks. Conversely, when experiences are committed by ex-partners, and a neighbour, respondents either sought formal support through DVA organisations or informally through friends and family. In all situations when participants sought support from friends and/or family, their accounts show this assisted them practically, and helped them resolve emotional trauma.

5.6: Chapter summary

By hearing the voices of 13 older victims, this chapter has provided rich accounts of the types of violence and/or abuse that older women experience, and shown how this can be DVA, NDA. It has unearthed how a range of factors are connected to their experiences, which includes age, generational differences, intersectional identities, dependency, shame, financial reasons, physical and/or mental health issues. It also indicates that a complex web of reasons influence survivors decision making when considering leaving relationships and/or seeking support. This chapter has also shown that older survivors are at risk from an array of perpetrators, including partners, adult children, a sister, professionals, and neighbours, and that sometimes a risk is posed by more than one perpetrator at once. All depending on who the perpetrator is,

my findings suggest that this further impacts on survivors. The type of perpetrator influenced how the impacts of violence and/or abuse was vocalised, who survivors assign fault and/or blame to, and what services and/or support networks were accessed.

Chapter 6: Experiences of professionals who work with women survivors

6.1: Introduction

This chapter presents the findings from 21 interviews with two distinct groups of professionals: DVA organisations and social services. Participant diversity regarding their role or team they work in, length of experience, and number of older women victims they have worked with, is provided below (see Table 12). Eleven participants work in DVA organisations, providing a range of services to victims who experience any type of DVA. Assistance includes outreach work, telephone support, counselling, advocacy, access to independent DV advocates (IDVAs), and accommodation in refuges. Ten respondents work in various teams within social services. Four out of these ten are in safeguarding teams, three of these are managers, who no longer support older victims directly but have experience of this. Participants in other teams could, at any point, encounter a service user who may require safeguarding. Both groups discuss their experiences of working with victims over the age of 60. This chapter outlines the experiences of these 21 practitioners, using their chosen names. The first section unearths their ability in recognising and responding to violence and/or abuse against older women, the second outlines the challenges they identify when working with older survivors, and the third highlights whether support needs of older victims differ from younger survivors. These findings are then discussed, and lastly a summary is provided.

Before proceeding, it is imperative to note that professionals from social services do not deliver interventions themselves (Chisnell, 2019). Instead, they investigate enquiries and can, for example, refer to, and work with DVA organisations. Their remit is wider than DVA organisations as it covers investigating victimisation within institutional settings and the community. Further, it includes cases of DVA (abuse perpetrated by intimate partners or ex partners, and family members), and victimisation committed by others such as care workers and neighbours. In comparison, the scope of DVA organisations is restricted to providing support to DVA survivors. As previously specified in Chapter 1, I refer to any type of abuse that does not meet the definition of DVA, as ‘non-domestic’ abuse (NDA).

6.2: Recognising and responding effectively to violence and/or abuse against older women

The below table (Table 12) provides details of the sample range and helps demonstrate their credentials for talking about their experiences of working with women victims over the age of 60. Their experiences included the number of victims they worked with, confidence to recognise and respond effectively to violence and/or abuse against older women, the types of training they had undertaken, and what types of interventions they put into place to support older victims.

Table 12: Summary of professionals' experiences of working with older survivors

Pseudonym	Role/team (self-defined)	Length of experience	Number or % of older women victims worked with
DV/DA/IPV professionals			
Abbie	DA support worker	6 years	2 in the last year
Sylvia	IDVA – support worker	14 years	3 or 4 in last year
Rachel	IDVA - support worker	16 years	10 in the last year
Mia	Local manager of DA support/refuges	1 year but previous similar DA support role (8 years)	1 in the last year, but *"more in previous role"*
Pink	DA support worker	2 years, 6 months	About 5 over career
Millie	Refuge support worker	9 months	1 over career

Bella	Support worker – outreach DA	8 years	4 over career
Jennyren	Senior support worker (refuge)	4 years	2 in the last year
Mandy	Assistant chief officer – previously manager of refuge	34 years	1 in 20 are older survivors
Vivian	DA support worker	20 years	3 in the last year
Jenny	DV and DA practitioner	2 years	10 in the last year
SOCIAL SERVICES			
Jean	Community wellbeing	1 year - previously worked in adult safeguarding (3 years)	15 out of 30
Isobel	Community wellbeing	3 years, but previously worked in older persons team within social services (7 years)	2 or 3 a month
Ellie	Community wellbeing	1 year	26 out of 30
Harmony	Adult safeguarding	7 years	On average: 80 %
Maria	Head of adult safeguarding	8 years in adult social work – 6 years	Implied as working with many over career but none currently (manager)

		in management	
Jessica	Adult/ older mental health	1 year, 7 months (newly qualified)	Limited so far
Betty	Independence team	9 months (newly qualified)	10 over career
Angela	Adult access manager	7 years in adult social work – 1 year in management	Half the reports that go to the team are safeguarding for older adults
Beryl	Safeguarding adult's manager	3 years in current role but previously worked in adult safeguarding team (5 years)	Implied as working with many over career but none currently (manager)
Anna	Ongoing assessment and intervention	10 years	Frequently

6.2.1: Number of victims/survivors professionals worked with

The number of older people accessing DVA organisations is low, with most DVA practitioners comparing this to younger groups, for instance:

> *"….the last year it's approximately 3, main bulk of our cases is younger. I have supported anywhere between 150 – 160 younger victims"* (Vivian)

Similarly, in the first UK criminological study, examining sexual violence against older women, Bows (2017b) found that the number of older survivors accessing specialist sexual violence organisations was low.

In comparison, my findings demonstrate that cases allocated to practitioners from social services, mainly comprise of older survivors. Cases for social workers are only low when the worker was newly qualified (n2). It is assumed this is because less experienced staff are allocated fewer cases. Nearly all professionals from social services (n8) frequently work with older victims, they did not specify if this was for DVA or NDA. However, Harmony estimated working with older survivors was 80% of her caseload. This correlates with statistical data, which indicates that safeguarding adult enquiries increase for older people (NHS Digital, 2018, 2019, 2020, 2021). As social services remit is wider than DVA organisations, this may explain the difference between the number of victims both organisations worked with. Offering some insight into this, Harmony said that because society tends to see older people as *"decrepit",* social services receive more referrals for older people, in comparison to younger adults. Similarly, Ellie said that due to *"impairments*", which are more likely for older people, violence and/or abuse was *"more on their radar"*.

Both opinions are identified in literature, which highlights how notions of decline and vulnerability underscore stereotypical ideas of old age (Jones et al, 2006; Pritchard-Jones, 2016). These constructions have manifold implications for the way organisations designed to provide support, treat older victims. For instance, it can lead to paternalistic treatment (Clarke et al, 2016; Lonbay, 2018). The view that older people are vulnerable and in need of protection could potentially result in organisations and/or individuals reporting victimisation to social services more frequently when compared to younger adults. Arguably, therefore, my findings support the notion that high referrals for older victims is influenced by the social construction of ageing. Nevertheless, it is unclear if respondents' views related to DVA and/or NDA. Consequently, no inference can be made about the types of abuse that might be influenced by notions of vulnerability and decline. Statistical data casts no light on this either because safeguarding data does not provide a breakdown by age of the types of abuse (Action on Elder Abuse (AEA), 2017). Notwithstanding this, while the stories of social workers infer high levels of referrals for older victims is influenced by the social construction of ageing, it is worth acknowledging that as people age, they are

more likely to have care and support needs (Chisnell and Kelly, 2019), and thus this can often bring them under the radar of social services.

Referrals from social services to DVA organisations are uncommon. Wydall et al (2015) reveal that statutory agencies often fail to recognise DA in later life and consequently, referrals from such agencies are rare. In Bows (2017b) study, no older victims were referred by adult safeguarding services. In slight contrast to Bows (2017b), my findings show some referrals to DVA organisations came from adult social services, albeit rare. It is feasible that since Bows (2017b) research, there has been a greater emphasis placed on social workers working closely with non-statutory specialist organisations. Guidance which seeks to support the implementation of the Care Act (2014) affirms the importance of organisations 'working together' and recognises DA as a category of abuse (Department of Health and Social Care (DoH and SC), 2014). While the impact of this led to changes in approach, Cooper and Bruin (2017) argue that significant cultural changes are required to deliver the safeguarding approach under the CA. It is possible these changes were still in transition when Bows (2017b) undertook data collection. Alternatively, the difference may be attributed to the type of victimisation. Bows (2017b) research examined sexual victimisation only. My study is wider and includes other types of violence and/or abuse. Nonetheless, referrals are still found to be rare, suggesting that there are still significant cultural changes required to break down the divide that separates those working in age related services and those in DA services (Wydall et al, 2015; Scott et al, 2004).

6.2.2: Confidence in responding effectively

Despite a lack of experience in some cases, some respondents (n4) from both groups convey confidence in recognising violence and/or abuse against older women, with some failing to understand how some practitioners might struggle:

> *"…go into a refuge because that doesn't happen. For us it is just, of course, everybody can be abused from any age. We've ladies in their 70s"* (Mia)

This contrasts with SafeLives (2016) data which suggests practitioners assume older women do not experience DA. Similarly, a social worker believes knowledge of violence and/or abuse against older women is just common sense for professionals.

While she did not specify if she was referring to DVA or NDA, her narrative implies it was DVA:

> *"I've always had an awareness. It's just common sense. If somebody's been fighting all their lives, it's not gonna stop because they've suddenly turned 60 or 65 or whatever arbitrary age you put on it."* (Isobel)

A high number of respondents (17) express confidence issues in recognising victimisation against older women. It is inferred this is resolved by gaining experience of working with older survivors. For instance, two respondents, one from social services and one who worked in a refuge, report their initial shock that it occurs and how this changed after commencing their current roles:

> *"I did not expect a lady of her age to be in here, but now it's opened my mind and shown us what really goes on. But I was massively shocked at just how common it is."* (Millie)

> *"…. the stereotypical view before being a social worker might be you wouldn't think that old people - I was shocked when I came in as a social worker, at how much abuse does happen. I was shocked because I would never have imagined it would, because you think, little old people, stereotypical views."* (Jean)

Jean also discusses stereotypical views that older people do not get abused, indicating this was her conceptualisation before becoming a social worker. She further suggests that unless people work with older victims, it is unlikely they will believe it occurs. Likewise, as part of her role, Mandy, assistant chief officer of a refuge, ran DVA awareness events in sheltered accommodation, churches, and other community venues. Mandy infers this helped her realise the extent of victimisation against older groups. As detailed below, findings indicate that gaining knowledge of older victimisation is essential. Taking this and the above together, it is suggested that an awareness of older victims and their needs is key to increase professionals' ability to recognise violence and/or abuse against older women.

6.2.3: Lack of specific training

All 21 participants said there is an absence of specific training that focused on victimisation against older women. For instance, Bella told me:

> *"…we've not had specific training which is concentrated on it."*

Although there is no specific training, all practitioners from both groups said safeguarding training had included all age groups from 18 and above. DVA professionals confirmed their DVA training covered all adult age groups. However, in both safeguarding and DVA training, it seems any type of abuse against older groups took less priority. For instance, an IDVA support worker said:

> *"We did talk about older women's experiences. We certainly talked about young women because younger women tend to be more at risk. It was touched upon, but it would be good for it to be more centre stage."* (Sylvia)

Sylvia infers the absence is due to statistical evidence that indicate younger women are more likely to be abused. The limitations of official figures have been highlighted by Bows (2019a), who expresses caution because this partial data is used to justify practice developments, which can include training. This concern is supported by my findings because no participants undertook formal specific training.

Sylvia further suggests that specific training is not required, and instead, awareness could be incorporated into existing training**.** Similarly, a social worker thought it could be subsumed into current training:

> *"I think it will be beneficial to be built into the training that we've already got."* (Isobel)

15 respondents were in favour of specific training, which mirrors Carthy and Bowman (2019) findings. Rachel, an IDVA support worker thought it *"would be useful"* because:

> *"I think people get scared if they have an 89-year-old suddenly on their case list. It's like, how do we deal with this? As with 14-year olds, it's the same sort of fears, that unless you've had experience of that age group, then it's quite scary."*

Going beyond just age, a DA support worker, who is *"a fan"* of introducing tailored training identified other characteristics and how specific training and services is needed for these:

> "*I'm always a fan of that. Also in terms of specific services sometimes as well, you have BAME women, LBGT, and different intersections of women have different problems or have extra problems, and it does need specialising".* (Pink)

While most participants (n17) agree there should be some form of specific training, four felt it was unnecessary because abuse occurs at any age. Reflecting on this, one social worker, Harmony draws attention to other factors for consideration which focus on health issues:

> *"When I go into training, I look at it that it can affect any age. I don't think of the elderly any different to people, abuse is abuse. The only difference is if there was mental health issues, you've got to take this into consideration, learning disability, dementia and things like that."*

These factors which may require consideration all relate to health (disability, mental health, and dementia). The tendency to discuss abuse in relation to disabilities and ill health is a common feature in most social workers stories. In doing so, their practices conform to the medical approach which focuses on what is 'wrong' with individuals, and not what people need to enable them to live independently (Shakespeare, 2017). This stance is outmoded and leads to marginalised individuals losing independence, choice, and control because it is assumed decisions need to be made on their behalf (Pritchard-Jones, 2018). Lonbay (2018), argues older people are affected more. Due to widespread ageism older people are considered as inherently vulnerable. As a result, their opportunities to be engaged in adult-safeguarding processes are reduced and rather than being empowered and involved, decisions are made on their behalf. It is unclear if this study was restricted to NDA, or DVA or included both. However, the stories shared in my study seem to support Lonbay (2018) conclusions. Social workers focus on vulnerability which inevitably leads to them undermining older people's

autonomy. Further, by taking this stance, their practices are anchored in ageist views, which arguably affects their ability to recognise and respond to older victims.

Although no respondents engaged in formal training, four (Pink, Jennren, Ellie, Millie) attended a seminar that addressed sexual violence for people aged 60 and over. Jennyren, for example, said:

> *"I attended a seminar with rape crisis but I haven't done any actual training on abuse against older people. I think that your knowledge comes with the more work you do with them."* (Jennyren)

This narrative suggests that practitioners mainly rely on gaining experience with older survivors, to facilitate their practice with this group. Ellie made similar comments and also reflects on how the seminar increased her awareness that DVA posters are generally pitched at younger groups and how this could lead to believing abuse only affects younger women, unless an awareness is gained:

> *"No specific training. See, it's difficult because I know from going on that older person seminar, but when you look back at all the posters who was young girls and young families, and thinking about it, is geared towards younger age."*

Carthy and Taylor (2018) and Kitzinger and Hunt (1993) both highlight the lack of attention given to older survivors through media campaigns, and Bows, (2017a) and Scott et al (2004) suggest this has detrimental impacts on victim's willingness to disclose victimisation. As discussed in Chapter 7, practitioners and survivors acknowledge there is a lack of awareness in society that violence and/or abuse against older people occurs. By taking heed of these stories, I support previous arguments that it is important for advertising campaigns to focus on older victims (Carthy and Taylor, 2018; SafeLives, 2016; Solace Women's Aid (SWA), 2016). Attention could help dispel myths that older people do not get abused. This may assist in reducing disbelief by professionals and encourage more older survivors to report victimisation.

During data analysis on training, an identified recurring theme is that while all DVA practitioners had completed mandatory safeguarding training, most practitioners from social services had no DVA training. As explored below, this arguably impacts on their responses to older DVA victims.

6.2.4: DVA and safeguarding training

All 21 professionals told me they regularly engage in mandatory safeguarding training. Likewise, to McLaughlin and colleagues (2018) findings some social work respondents (n6) said they had no DVA training. This lack of knowledge is worrying as it is likely to cause issues when trying to detect signs of DVA. Yechezkel and Ayalon (2013) found that social workers are less likely to identify IPA when survivors are older, and when abuse is psychological Findings from my study support this to some extent. Pink, a DA support worker, told me about one survivor who had sustained financial and emotional abuse, which then became physical. Social services were involved for some time, but a referral was only made to DVA specialist support following an incident of serious physical violence after the police insisted *"more needed to be done".* It, thus, seems that social services failed to recognise the psychological and financial abuse and contact specialist support, and that a referral was only instigated because of police involvement. The inability to identify DA and make appropriate referrals potentially leaves victims in vulnerable situations with little or no help (Robbins et al, 2016), which can have fatal consequences (Sharp-Jeffs and Kelly, 2016). In the case Pink explains, it is feasible that an earlier referral would have prevented harm. Similarly, to Carthy and Taylor (2018), and McLaughlin and colleagues (2018) findings, mine suggest that adult social services are not always equipped to effectively deal with DA in later life. It is therefore essential that adult services are trained to understand the unique dynamics prevalent in DA cases (Sharp-Jeffs and Kelly, 2016).

Most social worker respondents said training for DVA is not mandatory unless you work in children's services, for instance:

> *"it's offered, but it's not compulsory. But if I was in children's, it would be…."* (Jessica)

Robbins and colleagues (2016) suggest that the absence of compulsory training for social workers in adult protection reinforces the construction of DA as a child protection issue, which particularly impacts on older women because they are less likely to have dependent children. This feasibly contributes to the inability of professionals from social services to identify DVA because they assume it only impacts on younger women (Peckover, 2007).

While most practitioners from social services had a lack of DVA training, two indicate otherwise. Maria and Beryl infer training will only be sourced by managers who have an interest and/or knowledge of DVA. For example, Maria said:

> *"…with the laws around domestic abuse, it's really important to understand how that plays out and what it means."*

Maria commissioned DVA training but did not say if this was mandatory for all her staff. However, it seems that managers will implement DVA training for their staff when they have knowledge of it, and are interested in it:

> *"I did some focused sessions that were around domestic abuse. Domestic Abuse was what I wrote my dissertation on, so I've always had an interest in that field. I think that has helped knowing what to go out and look for with regards to training. … Two of my team have a real passion about domestic abuse and they're like, what can we train on? And this is needed, especially for domestic abuse, understanding the intricacies of what that means to that person, but also the agencies that can step in and help."* (Beryl)

The above also suggests that without DVA training there is a potential impact on the ability of social workers to understand the complexities of DVA and know what agencies to contact for help. The effect on older victims when professionals from social services lack training can arguably be seen in a DA support workers account. Reflecting on the inability of social services to understand the intricacies of abuse, which could have compromised a survivor's safety, Abbie said:

> *"It seems social services have yet to catch up with knowledge about the dynamics in abusive relationships. A social worker asked her why she didn't leave earlier. She closed off to everybody, but thankfully, I've had my training, and also my experience I was able to engage this client, and now she has opened up and engaging well."*

The findings suggest that an absence of DVA training is likely to impact on the ability of social workers to identify DVA. As set out below, it also seems to affect what interventions are initiated.

6.2.5: Impact on interventions

The ability of practitioners from social services to effectively respond to DVA for older victims is questionable. Bowen and Searle (2019) identify that due to a lack of professional competence, social workers often fail to identify DVA against elders. Prior to this, Wydall and colleagues (2015) show that some professionals believe adult care services divert older survivors away from specialist DA resources because they perceive them as vulnerable and/or because they do not recognise some forms of abuse as DA. In my study, the voices of practitioners from social services themselves support this finding to some extent. Their stories indicate that due to a lack of knowledge surrounding DVA, and perceived notions of vulnerability, there is a focus on addressing care and support needs and an absence of utilising DVA organisations. Basing interventions on care and support needs is apparent irrespective of whether abuse was NDA or DVA, and there was an accompanying lack of recognition that different interventions are needed, for example:

> *"Abuse is abuse. I would approach any form of risk of abuse seriously. So probably the same interventions."* (Harmony)

In the main, specific examples of interventions are not given. Instead, there is a tendency to discuss how any support offered is based on the victim's care and support needs. When examples are provided, it is evident there is no recognition that DVA requires a different response to NDA. For example, Betty discusses interventions she has initiated for victims, which includes installing an alarm on an individual's door when they lived alone and a key safe, so that only trusted people could gain access to their property:

> *"NRS, which is like assistive technology. So for a person living on their own, that when the door opens, the alarm goes. A key safe outside, so that only people that are trusted know that number…..I have contacted Age UK for loneliness, isolation. Support locally in the community, through Living Well, who support people with anxiety, depression, and getting out in the community."*

These interventions take no account of the complexity of DVA, are insufficient to minimise risk, and do not address power and control dynamics. They also fail to provide support for the impacts caused by DVA, such as trauma, and loss of confidence. Additionally, no protection is given against *"trusted people"*. This is

troubling because O'Keeffe and colleagues (2007) found that partners and family members are the most likely perpetrators.

Betty also identifies the types of organisations she has contacted. The services named address health issues, loneliness, provide general support to older people, and facilitate access to the community. Adult Directors of Social Services (2015) recognise that services meeting community care needs may play an important role in protecting someone from DA, for example, telecare monitoring systems. However, those delivering services must be aware of the risk and clear on what to do if the risk increases. It is unclear how the services Betty mentions would be able to achieve this. Further, they are not tailored to offer the emotional and practical support provided by specialist DVA agencies, and they are not designed to advise on safety plans. This raises concerns because risk of serious injury or death is more likely when older women are seeking help or leaving an abusive relationship (Brandl, 2000).

In another example, Anna, said when working with older victims she tries to meet eligible needs. This is mooted as beneficial because the:

> "*domestic violence may stem from carer break down, carer stress, unmet care needs, which were frustrating the individual".*

This takes no account of the dynamics of power and control which is prevalent in DVA situations (Rakovec-Felser, 2014). Moreover, it reinforces victim blaming connotations by somewhat excusing the abuse as resulting from frustration caused by carer stress (Wydall et al, 2018). This often leads to interventions being put into place for the carer instead of victims. An absence of specialist support for victims can have fatal outcomes (Sharp-Jeffs and Kelly, 2016). Moreover, Abbie, a DA support worker articulates how social services seem to have a lack of understanding of DVA. Telling me about one situation, she said they asked an older victim why she did not leave her relationship earlier. As a result, *"she closed off to everybody"* and refused to engage. This is concerning because it is when women, including older women, are seeking help, or leaving an abusive relationship that they are most vulnerable to serious harm or death (Brandl, 2000). Engaging with support services to minimise risk is thus essential. The findings therefore support Sharp-Jeffs and Kelly (2016) conclusions that it is essential for adult services to receive DA training to facilitate identifying and initiating appropriate interventions.

Conversely, Ellie who had undertaken shadowing at a refuge and attended a specific seminar on sexual violence against older women, informed me she has referred an older survivor to a refuge, and reflected on the benefits:

> *"(…) so we got her to the local refuge. And that was really good because it was like giving her that breathing space."*

While refuges are not the only option, or suitable in every case, it seems an effective intervention was initiated. Ellie is the only social worker who mentions contacting specialist support organisations which infers other participants had never done so. This further highlights the importance of practitioners from social services gaining an awareness of DVA and suitable pathways.

There was no indication from social workers that they would consider referring older survivors to legal services. Clarke and colleagues (2016) suggest that adult services are reluctant to discuss criminal and civil justice options with victims. They conclude this is due to a lack of knowledge and training required to adequately advise victims, and ageist stereotypes that the experience of seeking justice would be detrimental to the general health and wellbeing of elders. Given the focus on care and support needs, by social workers in my study, it is feasible to suggest they assume elders are vulnerable. Thus, my findings arguably support Clarke and colleagues (2016) because they infer professionals from social services do not consider legal redress for older victims because they see them as inherently vulnerable. A failure to offer legal action denies older victims the opportunity to have their voice heard through the criminal and/or civil justice system. Although pursuing matters through legal measures is not always the most appropriate course of action, practitioners should consult with older survivors and initiate support, where required, to help them access civil court remedies and/or criminal justice options.

DVA practitioners told me that support provided to older victims takes account of a multitude of factors including, health, debts, housing, and whether assistance was needed with legal matters. For survivors who wished to remain in relationships, support included drawing up safety plans. The need to tailor interventions was recognised, with Mia telling me this often depended on how much empowerment they needed:

"I've had some where they recognise that they've had all their empowerment stripped and they've been isolated and they want to gain control back. And some are so vulnerable and torn apart that they need an extra pair of hands to start the process but then let them go on and do it themselves."

6.3: Challenges services face

Six themes emerged that highlight challenges services face when working with each other, or older survivors and/or issues that impact on victims. These are working with each other, information sharing, mental capacity, age, assessing risk, and weaknesses of services.

6.3.1: Working with each other

Very few conversations took place regarding working with each other, and the findings indicate that referrals from social services to DVA organisations are rare. When this did happen, issues are highlighted. DVA workers told me that when referrals did come from social services, there was often no further involvement. This was problematic when older survivors had care and support needs. For example, telling me about a case that seems more like a case handover than a plan to work together, Jennyren said:

"One lady who was in her 60s, she couldn't do anything for herself. Social services were involved at first, but soon departed when I got involved. So yes, we're the experts in domestic abuse but that's just the presenting issue."

Jennyren said that while they were experts in dealing with DVA, this was often just the presenting issue. It was inferred DVA professionals are not trained to deal with health and care needs and how, for example, to assess and find suitable housing to meet their needs. Working with adult social services is implied as necessary to facilitate developing effective support plans for older victims.

Conversely, Jenny, highlighted a positive experience with social services and occupational health, which demonstrates the benefits of multi-agency working:

"We had a multi-agency meeting, and Adult Social Services were there and Occupational Therapists. I was really impressed by the pulling together of resources, that really benefited the client."

These findings support Blood (2014) and SWA (2016) who recognised the importance of DVA organisations and adult protection working together to develop packages of care that reflect the needs and wishes of older victims with community care needs. However, despite accompanying guidance to the CA that places emphasis on working together (DoH and SC, 2020, pg 14.7), the stories in my study suggest this is not always happening. This claim is further supported when considering Ellie's story, who said she had referred an older woman to a refuge (see section 6.2.5). However, she did not discuss working with them to develop a support plan. It was inferred that once the referral was made, her role ended. A failure to work together can impact on older victims because DVA organisations are not necessarily trained to understand possible age-related concerns, and the impact of specific care and support needs (Bows, 2017b; Carthy and Bowman, 2019; Shiel, 2016).

6.3.2: Information sharing

The most common example given concerning problems around information sharing, was data sharing and General Data Protection Regulations (2018) (GDPR). Statutory guidance to the CA emphasises the need to share information at an early stage (DoH and SC, 2020, pg 12.43). However, there is evidence that practitioners are uncertain about formal data sharing protocols, which is a potential barrier in providing effective support for older victims (Wydall et al, 2015). My findings support this to some degree. Accounts given by professionals show they are fearful of breaching GDPR. This caused issues when trying to gain information from other agencies at any stage. For example, a social worker said:

> *"…people still get hung up on GDPR and refuse. You've got two pieces of legislation which protect people. But sometimes they clash and you reach a stalemate, where we can't go forward without that, but you won't share it because of GDPR so how do we get around it?"* (Ellie)

The last phrase in the above extract suggests that some practitioners will try to find solutions. For one social worker, her *"philosophy"* was to possibly over share:

> *"For all we have GDPR, and information sharing and consent to share, people still worry about oversharing information that isn't required. Sometimes you*

> *don't know whether you should share or not….. I'd rather overshare and be stood in front of a judge saying I've overshared than be under sharing. And that's always been my philosophy."* (Angela)

Angela infers that disclosure of information depends on who is responsible for disclosing it. In her case, it is likely she would disclose information because she would rather *"overshare".* Consequently, it appears that problems with information sharing are mitigated if the person favours disclosure. The narrative of a senior support worker (refuge) supports the contention that it is dependent on who is asked:

> *"It sometimes depends on the agencies involved and sometimes the workers involved."* (Jennyren)

Similarly, but also reflecting on how location can make a difference, a DA support worker and a DV/DA practitioner told me:

> *"It's all down to the individuals. And locations, as well."* (Vivian)

It thus seems problems are sometimes mitigated by maintaining personal contacts. However, difficulties seem enhanced when information is requested from an organisation out of area and/or if it was requested over the telephone:

> *"Call an agency outside of area, they say, I can't give information. I understand because everybody wants to cover their back. They don't want to be falling foul of GDPR."* (Jenny)

There was commonality between both groups concerning information sharing, and how GDPR, location, and lack of proximity can magnify difficulties, and how personal connections, and/or preferences may alleviate them. While this inconsistent approach can impact on younger victims, it is potentially heightened for older victims. For information to be permissibly disclosed under GDPR (article 5, 1c), it must be relevant. Some practitioners do not believe older people can experience DA (SafeLives, 2016). This could cause services difficulty when trying to gain data from individuals, who hold stereotypical views, because they are less likely to appreciate the relevance. This postulation is not substantiated by the current findings and is arguably worthy of further investigation.

6.3.3: Mental capacity

Pursuant to the Mental Capacity Act (2005) (MCA) individuals are presumed to have capacity to make decisions, unless it is established that they lack capacity (s.1.2). Sometimes people choose to make *'unwise'* decisions and under MCA they have a right to do so (s. 1.3). This includes refusing support from agencies. The right to make *'unwise'* decisions is frequently discussed by all social workers. Their stories indicate a strong emphasis on allowing people to make decisions, even when these are *'unwise'*. Three social workers mentioned this in conjunction with DVA (Maria, Anna, Jessica). For example, Maria informed me of a case involving an older DVA survivor and how their right to make *'unwise'* decisions acted as an impasse:

> *"A woman who was very disabled, wanted to live with her partner. But he was was very risky. They are the hardest cases, because people have a right to make choices. And those choices may not be good for them. But if they've got capacity, you cannot interfere. People can make choices that are not necessarily good for them. And there's not a damn thing you can do about that."*

Thus, even when perpetrators are *"very risky"*, if people have capacity to refuse support, then it seems nothing will be done. A similar finding around capacity acting as an impasse was reported by Robbins and colleagues (2014). Moving beyond this, my findings suggest that there is an unwillingness to ask further questions to ascertain whether victims are exercising their own free will in refusing help. Research by Hoyle and Sanders (2000), indicates that survivors of DA are often unable to provide consent for interventions because they are unduly influenced by perpetrators. Consequently, assuming people are making informed choices because they have capacity, is fraught with difficulty and requires more discussion and training (McLaughlin, 2018). What already seems evident however, is that a refusal to engage should never be seen as a reason to do nothing (Robbins et al, 2014). Practitioners who understand power, control and coercion are more likely to support an approach that asks more questions, seeks more details, and intervenes (Wydall et al, 2015). While DVA professionals did not discuss mental capacity and the right to make 'unwise' decisions, Jessica, a social worker, told me she had previously spent over a year and a half working in a refuge. She said DVA organisations take a different approach to social services. When

specialist organisations encounter survivors who are resistant to support, they continue to inform them of their options and offer them support:

> *"I've seen with older victims, she's got capacity, she didn't want any help is a social workers point of view. Whereas the support workers point of view was, no we're going to try to keep on going, we're going to provide support, we're gonna meet them in secret place and offer them this is what we can do for them. And it was all, chipping away, trying to get them to have support and let them know they can be safe and there's a safe place to go."* (Jessica)

These accounts raise questions regarding the extent to which social workers recognise how control tactics used by DVA perpetrators impact on decision making. In contrast, DVA workers are trained to understand how power, control, and coercion impacts on victims, which seems to influence how they approach reluctant victims. My findings thus support Sharp-Jeffs and Kelly, (2016) contentions that adult social services should receive training on the dynamics of DA. This could facilitate their ability to assess if a refusal for support is based on undue influence or on autonomy. While, respondents recognised that the right to make *'unwise'* decisions could present challenges when survivors were younger but did not elaborate on this. However, as more enquires involve older people (NHS Digital, 2018, 2019, 2020, 2021), this is arguably more common for older groups. As considered below the impact of age is mentioned by DVA and social work practitioners in various ways.

6.3.4: Age

Age was sometimes a factor which impacted on practitioners in various ways. For instance, Ellie, who was in her 20s said her age presented a barrier to disclosure:

> *"Being young myself, they take one look and that's already a barrier that I've got to break down to get them to talk to us."*

Alternatively, a senior support worker in a refuge, who was over 60, suggested that her age increased her confidence to respond to EA:

> *"I felt more appropriate because of my age that I was working with older ladies"* (Jennyren)

Ellie narrative suggests that believes her younger age acted as a barrier preventing older survivors from engaging with her, while Jennyren's infers her older age helped her feel confident in supporting older survivors. Practitioners believing their age is an issue or attribute was found in Carthy and Bowman (2019) study. Moreover, reflections on the EVA project, which provides support to older abused women, highlight that older service users prefer an older support worker (Carthy and Bowman, 2019). It thus seems that Ellie and Jennyren's views in relation to their age are not erroneous, judgmental or based on prejudice.

Jenny a DV and DA practitioner said that in her experience older couples are more likely to be together all the time which makes it harder to speak to them alone:

> *"…because of age they usually together all the time. I know that it can be so for younger groups…but, they're always together, like, shopping together, staying together, going out wherever together."*

This can prevent them from receiving the help and support they need. Likewise, SafeLives (2016) suggests older victims are more likely to be accompanied by perpetrators, which impacts on practitioners' ability to talk to them and offer support. and thus, this perception does not appear to be judgmental.

6.3.5: Assessing risk

As discussed in Chapter 2, to assess risk, DVA organisations use the Domestic Abuse Stalking Harassment risk identification checklist (DASH) which consists of 27 questions. All eleven DVA practitioners confirmed this was the tool they use. They further discuss its lack of suitability for older women. Pink, for instance highlighted how older survivors have possibly lost two marks just by a matter of age:

> *"We undertake a DASH, and, assuming, and it's a big assumption, because I know people are having children later, you've got child conflict is one of the scores you've got, whether or not they're pregnant. Someone's lost two marks just by a matter of age."*

Similarly, Millie believes some questions are less relevant. She suggests DASH should be adapted to facilitate acknowledgement by older victims that they have been abused because they have greater difficulty recognising it:

> *"There's a few questions on there that are not relevant so I think there should be others…..Especially older people, some struggle to realise what's actually happening to them, so I think by asking questions, it triggers them to realise that's happening to me and that is abuse."*

The phrasing of some questions was also identified as potentially problematic. For example, Rachel, told me victims often suffer shock when they realise they have been abused. Consequently, she said she asks certain questions in a different way by avoiding using the word abuse and instead asking them what has happened:

> *"Two questions: is the abuse happening more often, and is the abuse getting worse? I ask the questions without using those words, because it can be quite a shocking thing to say to somebody who's been married to someone for 42 years, that you're being abused. And so, it's, tell me what's happening, tell me about what's going on."*

Due to the suitability issues with DASH, nine out of the eleven DVA practitioners told me that when cases fail to meet the necessary score, they ensure they are still heard at a multi-agency risk assessment conference (MARAC). They achieve this by using their professional judgement to *"push them through"* (Sylvia). It seems DVA professionals' understanding of DVA and how older women might face greater difficulty in recognising it, enabled them to find strategies to overcome issues with DASH. As discussed in Chapter 2, despite awareness of the differences older victims may face in recognising and responding to DA (SafeLives, 2016) little regard has been given to adapting DASH for older victims. The stories of practitioners' help demonstrate that more consideration should be given to adapting DASH to better suit the needs of older victims.

While DASH was recognised as having setbacks, all DVA practitioners recognise the importance of using DASH with most highlighting how it helps survivors identify they are being abused. This was emphasised as essential for older victims because "*some struggle to realise what's actually happening to them"* (Millie). In contrast, social workers inferred they do not use DASH, even when safeguarding enquires involved DVA. Instead, it seems there is a reliance on in house tools:

> *"We've got safeguarding tools so you can measure on a scale of things whether it high risk, low risk."* (Jean)

Other social workers also inferred they do not use DASH and instead, likewise to Jean suggested that risk assessment is a subjective process facilitated by in house tools, irrespective of if DVA or NDA is investigated. The practices of social workers in my study seem to adhere to the generic framework for risk assessment which was discussed in Chapter 2 (Social Care Institute for Excellence (SCIE, 2020a). While it is understandable DASH would not be used for NDA, it is not clear why it is not used for DVA. It is a resource that can be used by all professionals in public protection, including adult safeguarding (DASH Risk Model, 2021). For instance, DASH was implemented across all police forces in the UK from March 2009 and was heralded as a *'pioneering and significant step forward"* enabling all police services to use a common checklist for identifying, assessing, and managing risk (DASH risk model, 2021, n.p). The police, like social services, respond to reports of NDA and DVA. Consequently, there seems no reason why adult social services cannot utilise DASH when investigating DVA. Despite its issues, which were discussed above, DASH is vital because it is specifically designed for assessing the risk of DA (DASH Risk Model, 2021). It can help save and change lives through early identification, intervention, and prevention. Despite these clear benefits, as highlighted, social workers did not utilise DASH. As a failure to use DASH can lead to fatal consequences, Sharp- Jeffs and colleagues (2016) have raised concerns and conclude that social workers need to be trained to understand the complexity of DA, identification, and risk assessment. Furthermore, the use of DASH facilitates referrals of high-risk cases to a MARAC (Wydall et al, 2018). The absence of older people in MARAC is identified as contributing to the systemic invisibility of older DA victims (SafeLives, 2016). Consequently, by failing to use DASH for DVA enquires, the practices of social workers in my study arguably help shape and crystallise the notion that older groups do not experience DVA.

6.3.6: Weakness of services

An issue raised by all DVA professionals is the suitability of refuges for older women. Ellie was the only social worker that mentions refuges, but she does not comment on the suitability for older women. In contrast, Millie, a refuge support worker told me about one older survivor who considered returning to her abusive relationship to escape the noise of children:

> *"And that's what made her really sick of being here. Everything else was fine, but the children, she just wanted peace and quiet and a couple of times said she was going back home because she just wanted peace."*

Alongside issues relating to noisy children, there is recognition that due to disabilities, refuges might not be suitable. Due to this, Mandy told me that their organisation is looking to build a tailored annex for older survivors:

> *"Unless you can offer downstairs accommodation then that's more difficult for anybody with disabilities. We've been looking at some kind of annex or some different kind of accommodation because a lot of our over 60s, we have found over the years find it very difficult with the noisy children. So, it's very important with a new purpose-built refuge that you have some kind of annex, and a choice of whether you want to come through and be part of that big, noisy group, or whether you want to stay perhaps with your same age group in another part".*

While this was desired, Mandy said it is reliant on funding which could not be guaranteed. The benefits of specific services for older survivors are discussed in Chapter 3, alongside drawing attention to the challenges of sustaining such projects in the current financial climate (SWA, 2016).

Moving beyond specific weakness of service provisions, practitioners acknowledge the impact of *"cuts"* to services and/or difficulties in accessing them. Weakness in services, *"cuts"*, and the ability of victims to access support is said to impact more on older survivors due to a variety of reasons. For instance, Sylvia an IDVA support worker said:

> *"Mental health services are limited, and they often do an assessment but then no work with them because of cuts. They closed the mental health inpatient*

> *place here and closed it in the court and custody suite, the nearest are miles away. The impact is great. You haven't got enough of those services to meet the needs of older people and you haven't got access - if you live anywhere in the country to access a court, that's miles away, if you don't drive you haven't got access... there are no buses. If you haven't got any money you can't pay for a taxi. They are completely cut off. And they're cut off because they often won't have the confidence, which can stem from years of abuse, never having any control over their lives. And the isolation too, older women, especially in rural areas are really isolated and scared to talk because everyone will know their business."*

Previous studies reveal how older people are at increased risk due to isolation (Acierno et al, 2001; SafeLives, 2016), which is enhanced when living in rural communities (Teaster et al, 2006). Further, the above draws attention to how accessing services might be harder for older people who must rely on public transport, which is enhanced if they live in rural locations because there are *no buses*. Sylvia also highlights how women with limited finances might be additionally disadvantaged because they cannot pay for taxis. As explored in Chapter 1, older people, particularly women, are more likely to live in poverty (Women's Budget Group (WBG), 2018) and this is likely to impact on their ability to afford transport costs. Consequently, it is suggested that there is a need for outreach services, and for these to be in places where older victims are more likely to go and/or reside. For example, churches, Citizens Advice Bureau, community centres and supported accommodation. There is a recognised need to promote awareness in these environments and others. Blood (2014) and SafeLives (2016) both highlight the positive impact of providing outreach services and increasing awareness in areas where older people are more likely to go.

Similarly, Isobel, a social worker, reflects on budget cuts. She told me how previously she held a role, tasked with working with people aged 60 and over only. Due to cuts to resources, this team was later amalgamated into one service that deals with all adults. Isobel said that the previous way of working was beneficial because it provided more time to work with older victims, whose needs are which was no longer possible different:

“Their needs are different, if they have any kind of problems it's often coupled with, old age, ill health, physical, and all of the associated problems. So, having a separate team may be beneficial because you can really look at those. And now we can’t, it doesn't happen because we don't have the time”

Due to austerity and budget cuts, amalgamation of teams within social services has become more common (Cooper et al, 2018; Robbins et al, 2016). This is concerning because the complexity of abuse in the lives of older survivors require considerable opportunities to build trust, and discussions which show them they will be supported (Blood, 2004, Carthy and Bowman, 2019; Lewis and Williams, 2015; SafeLives, 2016; Scott et al, 2004). Without this they are unlikely to engage and could be left in serious risk. Consequently, the impact of cost saving measures is more likely to affect older DVA victims and raises real concern.

6.4: Support needs of older and younger victims

Practitioners from social services vary in their view on whether older victims' support needs differ from younger survivors. Anna believes that support depends on eligible needs only, irrespective of age:

“The support depends on their eligible needs, no matter their age. We try to make sure those needs were met, because the domestic violence may stem from carer break down, carer stress, unmet care needs, which were frustrating the individual which may have antagonized.”

This arguably also indicates a lack of knowledge of DVA, which is concerning because as explored in section 6.2.5 it causes victim blaming and leads to inappropriate responses that fail to consider the power and control dynamics in DVA situations. Conversely, other social workers recognise there may be differences between younger and older victims, but still frame their response in relation to care and support needs. For instance:

“They take up so much more time because they have really complex care and support needs.” (Isobel)

Irrespective of their different views, seven social workers said deciding what support is required is dependent on eligible care and support needs. This was regardless of whether abuse was NDA or DVA.

In comparison, DVA practitioners discuss needs that are uniquely relevant to DVA. For example, it was often recognised that abuse may be long term, resulting in victims needing more empowerment because they are generally in their relationship for longer and/or it is harder to change their way of thinking because the abuse had become more entrenched. Commenting on this Vivian says:

> *"They can need more empowerment due to the fact they've often been in that relationship so long. And it it's just having that knowledge to support them to have that confidence to build that self-esteem."*

This story also draws attention to the importance of gaining the required training necessary to support older victims. A few DVA professionals also told me that they may need additional time to help them come to terms with the abuse, build a new life and address the associated fear that accompanied this, this was especially enhanced if they had been in abusive relationships longer and/or most life had been spent in a community where they felt safe and secure. Mia said in comparison a younger person is less likely to be as settled and have fewer solid connections with friends, neighbours, and family who they are more reluctant to leave.

Alongside factors uniquely relevant to DVA, health needs are recognised and how this can create a greater dependency on others. However, it is further acknowledged that care and support needs do not necessarily depend on age*:*

> *"...we all have different needs, it depends what those needs were. But her immediate needs of coming into the refuge would be safe accommodation, sorting out money, and funding which you do with any age. And future housing, then it would depend on health issues, or if she needs particular aids."* (Mandy)

Most social workers focus on delivering support based on survivors' care and support needs and fail to identify anything specific to DVA. In contrast, DVA practitioners reflect

on support needs uniquely associated with DVA, such as needing more empowerment, and recognised health issues and other needs.

6.5: Discussion

This section discusses the main findings and when possible, compares them to previous research. Likewise, to Bows (2017b) my findings indicate that the number of older victims accessing specialist organisations is low in comparison to younger groups. Additionally, they show how they are low when compared to the number of older victims' social workers supported. Social workers suggest that the high number of referrals to them is linked to the social construction of ageing and vulnerability but did not specify if this was for DVA or NDA.

Most DVA practitioners and social workers said they lacked confidence in recognising victimisation against older women and suggested that gaining an awareness of older victims and their needs was key in increasing their ability to identify it. Professionals from both groups told me they received no formal specific training. Nevertheless, similarly to Carthy and Bowman (2019), most express a willingness to receive it, indicating it would facilitate gaining the required knowledge to effectively support them. Gaining training to understand the unique dynamics present in DA cases is essential to reduce risk (Sharp-Jeffs and Kelly, 2016). DVA practitioners also welcome working more closely with social services when victims have community care and support needs. This supports Blood (2014) and SWA (2016) who recognised the importance of DVA organisations and adult protection working together to develop packages of care that reflect the needs and wishes of older victims with community care needs. However, I found that social workers rarely refer to DVA organisations and suggested that this is influenced by ageist views that prevent people from recognising older people are abused. Similarly, to Clarke and colleagues (2016) findings, it seems ageist views prevent professionals from social services from considering civil and/or criminal justice options.

Echoing past research (McLaughlin, 2018) it was apparent that social workers rarely undertook DVA training. Only two out of ten had engaged with some form of formal DVA training. It is inferred that this, alongside perceived notions of vulnerability, affects their ability to recognise and respond to older DVA survivors effectively. This is concerning as the ability to identify DVA and make appropriate referrals helps reduce

the risk of fatalities (Sharp-Jeffs and Kelly, 2016). Further, it is indicated that the absence of knowledge of DVA impacts on social workers ability to assess whether victims are truly exercising their free will when they refuse help. Assuming potential victims of DVA have the capacity to make choices neglects the wider context of living with abuse and how perpetrators control access to external support (Robbins et al, 2016; Hoyle and Sanders, 2000). In relation to risk assessment, social workers do not utilise DASH even in DVA cases. This could further affect their ability to identify older DVA victims as the inhouse tools used do not recognise DVA as a category of abuse (ADASS, 2011). Additionally, the skills required to assist the police (if matters reached a criminal level) may need developing or refining (Manthorpe and Bowes, 2016). Given time constraints and heavy caseloads (Lonbay. 2018), it may be somewhat difficult to acquire or improve their skills effectively to safeguard DVA victims. Further as DASH to facilitates referrals of high-risk cases to a MARAC (Wydall et al, 2018), the failure to use DASH for DVA enquires arguably contributes to the systemic invisibility of older DA victims (SafeLives, 2016), and further helps shape and crystallises the idea that older people do not experience DVA. In contrast, DASH was used by all DVA professionals. While they identify this tool has setbacks it was seen as a useful aid which helped older victims recognise their situations as abusive. Their stories further infer that their understanding of DVA and potential issues older victims might face, helps them overcome the issues associated with DASH. Their stories also give rise to arguments that it is necessary to consider adapting DASH.

A key challenge brought to the forefront is the difficulties with information sharing. Due to fears of breaching GDPR, which seemed to be linked to uncertainty about formal data sharing protocols (Wydall et al, 2015), practitioners do not always wish to disclose data. This reluctance is enhanced if the organisation is out of area, or information is requested over the telephone. Difficulties are mitigated if information is requested from personal contacts or if the person asked favours disclosure. Age is found to present issues for professionals when they were trying to encourage older victims to talk to them and/or provide support because they are more likely to be with their partner all the time. Additionally, the older age of practitioners was seen as an attribute, because older survivors like to talk to and work with older professionals. Moreover, weaknesses in service provision were highlighted by both groups of practitioners, particularly the impact of *"cuts"* to services and/or difficulties in accessing them. Due to differences in

support needs and weakness in service provision, the findings suggest that outreach services are required, alongside developing specific teams, approaches, resources, and safe accommodation for older survivors. They also support previous arguments that media campaigns need to focus on older women (Carthy et al, 2018; SafeLives, 2016; SWA, 2016), and that there is a need to promote awareness of violence and/or abuse in environments where older people are more likely to go (Blood, 2014; SafeLives, 2016).

Attention is drawn to how social workers only focus on victims' care and support needs when considering interventions. Except for one case, the findings suggest that no thought is given to if abuse is DVA or NDA. As a result, support is initiated that takes no account of the intricacies associated with DVA, such as empowering victims, or building safety plans. Women, including older women are most at risk when they are seeking help, or leaving an abusive relationship (Brandl, 2000), and thus this causes grave concerns. My findings thus support Sharp-Jeffs and Kelly (2016) conclusions that social workers should undertake DVA training which takes an intersectional approach which allows for an understanding of how multiple systematic and individual factors compromise older women's ability to achieve or uphold self-sufficiency (Nerenberg, 2002). In contrast, DVA practitioners considered a variety of factors, including health, and provide additional support and encouragement to help older survivors make disclosure, aid their recovery, and gain some control over their lives. They acknowledge the issues surrounding the suitability of refuges and support the introduction of purpose-built facilities to accommodate for older victim's needs. Similarly, to past observations (SWA, 2016), the problematic nature of this, in the current climate where services are dependent on funding, is highlighted.

DVA professionals' recognition that support depends on various factors arguably helps show how classing violence and/or abuse against older women as EA is problematic. Such approach fails to take account of their needs because the focus is on age and/or age-related issues (Blood, 2004; Bows and Westmarland, 2017; Harbison, 2008; McGarry and Simpson, 2010, 2011; Lazenbatt et al, 2013, 2014; SafeLives, 2016; Wydall et al, 2015). Further, in turn an age-related approach reinforces notions of frail, dependent older people (Hightower et al, 2006). It seems that the practices of social workers in my study were influenced by these notions as they solely focused on care and support needs and failed to implement interventions to address DVA. This can

leave them without the support they require to manage their abusive situations and potentially place them at significant risk (Brandl, 2000; SafeLives, 2016; Scott et al, 2004; Sharp-Jeffs and Kelly, 2016).

Lastly, the findings draw attention to the need for further research that explores the impact of coercion and control on traumatised individuals when assessing mental capacity, and how information sharing might be impacted by stereotypical that older people do not experience abuse. Additionally, the stories of the 21 professionals' experiences, sheds further light on the nature and impact of violence and/or abuse against women ages 60 and over. This will be set out and discussed in the next chapter.

6.6: Chapter summary

This chapter has set out the findings of the experiences of DVA professionals and social workers who have experience of supporting older survivors. It has highlighted their ability to effectively respond to victimisation by exploring the number of victims they have supported and assessing their confidence in doing so. It also considered the types of training they have undertaken and the impact this has on their ability to effectively recognise and respond to violence and/or abuse against older women. The six challenges both services faced were also detailed and included working with each other, information sharing, metal capacity, age, assessing risk, and weakness of services. The views on whether support needs of older victims differed in comparison to younger groups was also given attention, and it was found that there weas variations in how age was interpreted.

Chapter 7: Professional's perspectives of the nature and impact of violence and/or abuse against older women

7.1: Introduction

The findings presented in this chapter shed further light on the nature and impact of violence and/or abuse against women aged 60 and over. The 21 interviews with professionals from DVA organisations and social services highlight the type of violence and/or abuse against older women, and various factors which impact on their help seeking behaviour and the support they require. With the aim of providing a higher-level analysis, their accounts, when possible, are linked to the stories of the 13 older women who took part in my study. Following this, this chapter discusses the findings. A chapter summary is then provided.

Before proceeding, it is essential to note that none of these 21 practitioners have supported any of the older survivors in my study. Also, it is important to reiterate that social workers' experiences of working with older victims covers abuse that occurs in institutional settings and the community. Further, their remit in community settings includes victimisation perpetrated by intimate partners, ex partners, and family members (DVA), and abuse committed by others such as care workers. Consistent with other chapters, this chapter refers to victimisation that is not classed as DVA, as non-domestic abuse (NDA).

7.2: The nature of violence and/or abuse against older women

As shown in Table 13 and 14 both sets of professionals identified several types of violence/and or abuse which older victims have disclosed to them.

Table 13: Older victims experiences of types of abuse, as reported by social workers.

Pseudonym	Types of abuse	Environment
Jean	Physical, financial, and neglect Medication errors, and neglect	Institutional Community

<table>
<tr><td>Isobel</td><td>Neglect, theft, missed calls, and medication errors

DVA</td><td>Institutional and community

Community</td></tr>
<tr><td>Ellie</td><td>Financial, neglect, and DVA</td><td>Community</td></tr>
<tr><td>Harmony</td><td>Sexual

Financial and neglect</td><td>Community

Institutional</td></tr>
<tr><td>Maria</td><td>Heightened sexual activity

Neglect, self-neglect, and DVA</td><td>Institutional

Community</td></tr>
<tr><td>Jessica</td><td>Physical

DVA</td><td>Institutional

Community</td></tr>
<tr><td>Betty</td><td>Self-neglect, theft, neglect, and financial</td><td>Community</td></tr>
<tr><td>Angela</td><td>Physical, psychological, financial, neglect

DVA</td><td>Institutional and community

Community</td></tr>
<tr><td>Beryl</td><td>Neglect, and sexual</td><td>Institutional</td></tr>
<tr><td>Anna</td><td>Physical, neglect, medication errors, and financial abuse

DVA</td><td>Both

Community</td></tr>
</table>

Table 14: Older victims experiences of types of abuse, as reported by DVA workers.

Pseudonym	Types of abuse
Abbie	*"Every type"*
Sylvia	*"All of them"*
Rachel	Physical, sexual, financial, and emotional
Mia	Physical and financial
Pink	Physical, financial, and coercive control
Millie	Financial and coercive control
Bella	Physical, financial, and sexual
Jennyren	Physical, financial, sexual, and coercive control
Mandy	Financial, coercive control, and emotional
Vivian	Physical, emotional, and mental
Jenny	Emotional, sexual, and verbal

As shown, a wide variety of abuse is identified by both groups. These various types of abuse have also been found in other UK studies (O'Keeffe et al, 2007; Naughton et al, 2010). However, these studies excluded institutional settings. Social workers in my study also had experiences of investigating victimisation in these settings, these findings and analysis are explored in section 7.2.4. The following sections set out the findings in relation to some of the types, professionals told me about, and where possible show how it connects with the voices of survivors that took part in my study.

7.2.1: Neglect

Social workers undertake safeguarding enquires in community and institutional settings. Respondents seem to have more experience of working with survivors in the community, as eleven report types of abuse in this setting, compared to seven for institutions. However, irrespective of the setting a common type discussed was neglect. Nine out of ten social workers said cases for older victims often involved neglect. Commenting on this Maria said:

> *"Often the highest percentage are around neglect. So now is that purposeful neglect or is that neglect as a result of lack of time, ignorance, because we don't*

> *give providers sufficient funding to deliver care in the way it needs to be delivered. We certainly don't prioritise Social Care."*

This accords with O'Keeffe and colleagues (2007) findings, and Safeguarding Adults Collection (SAC) data (NHS Digital, 2018, 2019, 2020, 2021) which suggests that neglect and acts of omission are the most common type of abuse experienced by older people.

Out of the seven social worker participants who told me about enquiries into institutions, three said investigations often involve looking into poor standards and neglect. For example, commenting on standards:

> *"It's about the quality of their life and how staff cultures and all the things that would make someone's day really meaningful, we've got a massive job nationwide to improve the quality of care."* (Beryl)

Discussing neglect and standards, Angela said:

> *"Anything from at lunchtime he only had a small plate of dinner, to the toilets were broken, or the lift."*

Both drew attention to the difficulties of providing adequate care and standards which seems to be a result given the current financial climate. Additionally, Maria's narrative above draws attention to the potential impact of a lack of social care funding. All three said that the impact of cuts affects the quality of care in care homes, which could lead to neglect. Similarly, as discussed in Chapter 5, two victims in my study (Korine and Caroline) told me about their experiences of neglect in a care home. Both said it was not the fault of care staff because they had so many others to look after or were so busy. Bawden (2017) argues that austerity has led to the chronic underfunding of the social care sector and Burns and colleagues (2016) highlight the impact of financial cutbacks in some homes. As a result, the quality of support provided is impacted negatively, which as discussed in Chapter 2, is reinforced by the rhetoric of neoliberalism (Culpitt, 1999) and the undervaluing of people with care and support needs, who tend to be older (Chisnell and Kelly, 2019). The combination of the voices of two survivors and three professionals in my research, arguably helps show how social funding cuts negatively impacts on the quality of care provided in care homes which is driven by neoliberal ideology. Although the experiences disclosed to me did

not seem to pose a serious risk of harm, 'sub-optimal' care and neglect can result in fatalities (West Sussex Safeguarding Board, 2014).

7.2.2: Sexual victimisation

The least frequently discussed type by social workers was sexual victimisation. Only Harmony and Beryl had made enquiries into sexual abuse, and Maria said she has investigated heightened sexual activity. It is unclear how many cases of each have been investigated. Heightened sexual activity was contextualised in an institutional setting but Maria did not explain what this type would include. It is also unclear if Harmony and Beryl were referring to institutional or community enquires. Irrespective, it seems evident sexual abuse was the least type of abuse they had enquires for. This resonates with past studies that indicate that sexual abuse is the least commonly reported type of abuse in community settings (Naughton et al, 2010; O'Keeffe and colleagues, 2007) and institutional settings ((Allen et al, 2003; Ludvigsson et al, 2022; Yon et al, 2018). The proportion (n 6), of DVA professional supporting older sexual violence/abuse victims is higher when compared with social worker respondents (n3). When compared to the other types DVA professionals told me about, sexual abuse was the third lowest, alongside emotional abuse. I do not argue my data conflicts with past studies (Naughton et al, 2010, O'Keeffe et, 2007) because my findings cannot be generalised. While past research is not capable of drawing acute incident rates, 2,100 people were surveyed in O'Keeffe and colleagues (2007), and the sample range in Naughton and colleagues (2010) was 2,021. Consequently, this data has more validity than mine.

Telling me about cases of heightened sexual activity she has investigated in care settings, Maria said often no action is taken. She explains this is because people with dementia can often be seen as being sexually abusive when they are not wanting to be. As noted above, no indication of what heightened sexual activity involved was provided, but Maria seems to suggest it is when people sexually touch themselves without meaning to. If this interpretation is correct, heightened sexual activity can be termed inappropriate sexual behaviour (ISB), and is a relatively common form of behaviour in people with dementia (De Giorgi, 2016). One survivor in my study disclosed sexual victimisation to me. Caroline told me that while she was temporarily in a care home, a male resident was exposing her to sexual touching of himself. She

said she did not believe he was in control of what he was doing because he had dementia. Thus, like Maria, she seems to recognise that dementia may cause individuals to display ISB. Caroline believes his acts were directed at her because he looked at her while he touched his groin. She was scared and distressed, an outcome that seems acknowledged (Kamel and Hajjar, 2004). However, it is feasible his acts are misread. ISB, which includes genital touching, can be misinterpreted as sexual, when instead it results from pain, discomfort, hyperthermia, or attempts to be freed from a restrained environment (De Giorgi, 2016). Although Caroline's experience presents as atypical, it displays the scope of possible misinterpretation given the complex interplay of age, vulnerability, and people with dementia.

Sexual abuse cases investigated by social workers is low, and this type of abuse is the third joint lowest disclosed to DVA practitioners. Only one victim (Caroline) reports this type to me. My findings, when considered with past research, therefore infer that sexual abuse of older women is often not experienced. It is feasible that this is linked to ageist attitudes that see older women as sexless, rendering them as unlikely targets of sexual violence (Connolly et al, 2017). These socially constructed notions prevent practitioners from comprehending that elders can be victims of sexual attacks (Bows and Westermarland, 2017), and arguably makes it harder for survivors to recognise and report it.

7.2.3: Financial abuse

Financial abuse was identified as a frequent type by both groups of professionals. Six social workers told me about enquiries into financial abuse. Nine DVA professionals told me they have supported victims of financial abuse, and eight said they have worked with survivors of physical abuse. It is indicated that these are the main types. Commenting on this, Mia said:

> *"…the main two I've experienced in older is physical and financial."*

Findings from both groups of practitioners demonstrates that financial abuse is high. It was the highest type reported by DVA professionals, and the second most prominent category social workers highlighted. This corresponds with the frequency levels disclosed by survivors in my study, as financial abuse was the second most reported type by them. This could be linked to the economic instability caused by the current financial crisis. With limited access to resources, individuals might choose money over the trust and wellbeing of an older person, and abuse their position of power by taking

advantage of them (Nursing Home Abuse Centre, 2022). Financial abuse has also been found to be high in past studies. For instance, research conducted in the USA (Acierno et al, 2010), and a study carried out in Ireland (Naughton et al, 2010) both found financial abuse by a family member to be the most prevalent type. While O'Keeffe and colleagues (2007) found neglect to be the most prominent type of 'mistreatment', financial abuse was next. Further data from the Criminal Survey for England and Wales suggests financial abuse is one of the most frequent types that those aged 60-74 experience (ONS, 2018). Thus, the combination of my two data sets from survivors and professionals seems to correlate with past research, as it indicates that financial abuse is either the most, or one of the most reported types of abuse against older women. However, social worker respondents did not specify if the incidents they investigated were in community settings or institutions. Within institutions financial abuse is common but is not as frequent as other types including physical, psychological and neglect (Allen et al, 2003; Melchiorre, 2014; Saveman et al, 1999; Yon et al, 2018). Nevertheless, it was still reported in these past studies and was never the least type reported, thus suggesting it is relatively common.

7.2.4: Violence and/or abuse in institutions

A previous review and meta-analysis suggest that abuse in institutions settings is higher than in the community (Yon et al, 2018). While my findings cannot be generalised, survivors and social services respondents' voices conflict with this. Two victims discussed victimisation in a care home, ten told me about incidents in their home or the community, and one described abuse in both settings. Seven social workers informed me of enquiries into institutions, which were mainly for care homes, while nine had experience of working on cases in the community. While my combined data conflicts with Yon and colleagues (2018) findings, it is likewise to SAC data which indicates that abuse in institutions is the second most common risk location in England (NHS Digital, 2018, 2019, 2020, 2021). Nevertheless, SAC data includes all ages from 18 onwards, but as more enquires involve older people, it can be inferred that this risk location is common for elders. Examining victims aged 60 and over, Bows and Westmarland (2017) identified institutional settings as the second most common location in the UK. However, this research specifically focused on rape and sexual

violence and therefore does not cast light on other types of violence and/or abuse, such as physical or emotional.

As research is still in its infancy, little is known about the extent and nature of abuse in institutions (Yon et al, 2018). The types of abuse victims disclosed to me were sexual (1), and neglect (2). Three social workers told me about neglect in institutions, but only one (Beryl) discusses investigating sexual abuse in institutions, and Maria told me about heighted sexual activity. Therefore, my findings suggest that sexual abuse in care homes is low, and various research supports this because sexual abuse is the least reported type occurring in different institutional settings (Allen et al, 2003; Ludvigsson et al, 2022; Yon et al, 2018) Nevertheless, to substantiate this finding, further research is warranted examining reports of different types of victimisations in institutional settings, in the UK.

Other types of abuse in institutions were reported by social workers. This includes, physical, missed medication, missed calls, challenging behaviour, self-neglect, and medication errors. Possible misuse of medication was found by Maguire and colleagues (2003), and medication errors were identified in a safeguarding review (West Sussex Safeguarding Board, 2014), and by Furness (2006). While my combined findings help cast some light on different types of abuse, more research exploring the nature and characteristics of violence and/or abuse in institutions is warranted.

7.3: Factors which impact on older women's help seeking behaviour

Various factors that often merge and produce a complex picture of older women's experiences of abuse, are frequently acknowledged. As set out below, these are age, generational differences and accessing services; multiple intersecting factors; increased likelihood of vulnerability, disability, and/or length of time in their relationship; and the relationship between victims and perpetrator.

7.3.1: Age, generational differences, and accessing services

When discussing how age impacts on older victims, this is sometimes contextualised in relation to generational differences. For instance, one DVA worker told me how it is harder to break down barriers due to age and generational differences:

> *"Older generations come from an era where everything is kept in the family, you've made your bed, you lie in it. No matter if it's financial, physical or neglect, it's always kept in-house and it can be really difficult to break those barriers. Whereas younger generations are told refuges are there, you've got support and are more open to it."* (Jenny)

Several DVA practitioners identify how older victims seem less aware of services than younger survivors. For instance, Pink, a DA worker, said they were often shocked that they could get support:

> *"There is a lot of shock that the support is there, shock that they are being listened to. They didn't know that we were here and that we were there to do that."*

Similarly, Ellie, a social worker told me about a victim who struggled to understand that refuges were an option at her age:

> *"She was very, you've got all these mothers and young children in here and then you get me who's 79, and it was trying to explain actually, it doesn't matter what age you are, refuges there for people who need it."*

As set out in Chapter 5, the way age connected with victims' experiences varied. Although Ricky said her age did not stop her from recognising her abusive situation, she also tells me she was shocked at what support she could receive. She never knew services existed and that they were there to listen to her. Scarlett, who explained abuse by her adult son, said she felt embarrassed when she accessed DVA services because she thought they were only for younger women. As explored in Chapter 3, due to the era older women grew up in, there was an absence of DVA services, and when they did come into fruition, they were inadvertently not designed with older women in mind (McGarry and Simpson, 2010, 2011). Also, media campaigns mostly portray images of victims as young adults and children (Carthy and Taylor, 2018). This ageist perception may shape and crystallise a societal view that DVA is only experienced by younger women. In turn this may prevent older survivors from recognising their experiences as DA (Scott et al, 2004), and hinder lay people from believing it can occur. As a result, Blood (2004), SaveLives (2016), and Scott and colleagues (2004) all suggest that older women are less aware that services exist or

believe they are only for younger women. The combination of my findings, from the voices of DVA professionals and two survivors' support this.

Practitioners in sexual support services acknowledge how older survivors lack awareness of specialist support services (Bows, 2017b). Responsibility for is seen as multifaceted, and all practitioners felt they, or their organisations had a part to play in raising awareness. Similarly, most DVA workers in my study said the perception that services are only for younger women needs to be addressed. This could partially be achieved by increasing awareness of abuse against older people. Mandy, a chief assistant of a refuge said she hoped to do this by delivering talks and holding awareness events at places older people are more likely to go or reside. She further told me how she was often thanked for this as she was reaching out to those that have not been reached before:

> *"A lot of my role was Domestic Abuse Awareness in the community. So, I was reaching that age group on a weekly basis, whether I was going to talk to church groups, sheltered accommodations, whatever. And most said, oh, I wish we'd had that help and support years ago. They believe we're reaching out to those that have not been reached before."*

Feedback from older women who engaged with The Silver Project emphasise how they believe there is a lack of awareness of abuse against older women (Solace Women's Aid (SWA, 2016). Additionally, they felt this should be addressed. The survivors in my study mirrored this view to some extent. They thought more could be done to increase awareness of violence and/or abuse against older people and hoped by taking part in my research, their stories could elicit change. Tying this together with the voices of professionals, my findings support the view that there is a lack of awareness that services exist (Blood, 2004; Bows, 2017b; SaveLives, 2016; Scott et al, 2004) and a keen desire to prompt change by professionals and survivors themselves.

Alongside age and generational differences, DVA workers also talk about a multitude of factors which impact on older victims' willingness to leave relationships or seek support.

7.3.2: Multiple intersecting factors

This section considers the multiple factors DVA practitioners discussed, which often combine to produce a complex layering of experiences that make it difficult to appreciate the predicament of older women victims.

Alongside generational differences, DVA practitioners identified various complex and often overlapping factors that impact on older victims. These include increased vulnerability, invisibility, mobility issues, hearing problems, vision problems, isolation, a lack of confidence, financial considerations, living in rural areas, the length of time in the relationship, fear of change, and losing their home. Some of these have been suggested by past research and observations (ADASS, 2015; Blood, 2004; Bowen and Searle, 2019, McGarry and Simpson, 2010, 2011; SafeLives, 2016; Straka and Montminy, 2006; Teaster et al, 2006, Zink et al, 2003).

Commenting on various factors, Sylvia highlights how finances, making their own decisions, and a lack of confidence, affects older survivors' willingness to gain independence:

> *"I have found that because they've often been forced to be very dependent financially, in decision making and all sorts of things they lack the confidence to actually start on a new life. You know, it's a massive thing that the older you are, the more difficult it is to get through that sort of barrier. Because change is very scary."*

Commenting on one case, Pink told me about an older survivor who had a lack of understanding of finances which caused several issues when she left her husband. The impact of being in a controlling relationship for years, and the various types of abuse she endured are also mentioned:

> *"She didn't have any understanding of finance and when it came to leave him there was a lot of problems. She didn't know who was paying the phone, she didn't know who was paying the TV, didn't know who was paying the gas, anything like that because it all had been controlled by him, she didn't even know how much money she had, which was an act of abuse in and of itself, although she didn't quite see it until afterwards (…...) He pushed her on the floor and drove his fist into her chest. And she went and called the police and*

she was on the phone to the police and while she had no shoes on he stamped on her foot with walking boots and he scratched her face round by her eye and fractured her foot.”

Rachel, an IDVA support worker, identifies increased vulnerability, mobility issues, hearing problems, vision problems, and systemic invisibility. She said some of these can limit older survivors ability to communicate and access services:

“A lot of the time when I am dealing with somebody older, they’re worried about what they will loose. Even when they recognise, they’re at risk, they have security in terms of home and finances. So a lot of it, they accept – they understand that person’s abusing but they think about the other stuff they will lose if they decided to leave.”

Mia draws attention to the same factors as Rachel, and adds isolation, and what older women think they might lose if they leave, especially their home:

“A lot of the time when I am dealing with somebody older, they’re worried about what they will loose. Even when they recognise, they’re at risk, they have security in terms of home and finances. So a lot of it, they accept – they understand that person’s abusing but they think about the other stuff they will lose if they decided to leave.”

Emotional attachment to their home was emphasised as a key reason for not wanting to leave their abusive relationships. This barrier combined with how their whole life has often been spent in a community where they feel safe and secure. DVA professional told me how survivors would risk their safety by remaining in abusive situations because leaving their homes is inconceivable. They draw attention to how older women will often remain in very risky relationships because they worry about losing their home. They said this fear was escalated for older survivors because most of their life had usually been spent in their home, and they were tied to their community where they felt safe. Two survivors in my study (Ricky and Joan) told me that they were reluctant to leave their relationships because they did not want to lose their homes and move out of their community. Additionally, they told me that if they moved, they may lose contact with their good friends and neighbours. Rowles and Chaudhury (2005) suggest the meaning of the home is often magnified in later life, and Tomini

and colleagues (2016) highlight how networks of family and friends are vital for older people. Carthy and Taylor (2018) and Bowen and Searle (2019) found that professionals believe older victims are fearful of losing their home because it means rebuilding their whole lives away from significant networks. Although my findings cannot be generalised, by sharing the stories of Ricky and Joan, and tying it to professional views (both in my study and others), it is possible to start unpacking how the meaning of the home and being close to social networks, impacts on older victims. It is suggested that older women are more reluctant to leave their homes than younger women because it is where they spend most of their time and leaving would mean rebuilding their whole lives away from a community where they feel safe and are surrounded by essential social networks.

Age, generational differences, and a variety of other factors are identified as issues which impact on older victims' ability to recognise abusive situations and escape them. However, some of these were only mentioned by DVA professionals. Although it was recognised younger survivors can face similar issues, DVA practitioners often acknowledge these were more acute for older women due to the length of time in their relationship, increased likelihood of vulnerability, and/or care and support needs. This is considered next.

7.3.3: Increased likelihood of vulnerability, disability, and/or length of time in their relationship

Increased vulnerability due to care and support needs was seen as impacting on older women's ability to leave their relationships. Discussing an older woman who accessed outreach services but then disengaged, Abbie draws attention to how disability combines with fear to create a situation which prevented one victim from leaving:

> *"She was scared. I think she probably still is scared. For whatever reason, she couldn't get out of that situation, whether it be because of the learning disability, or the fact that her husband didn't have a learning disability, and he was taking full advantage of that. ….he will be ensuring that she is saying all the right answers to get control of her money."*

Alongside disability, the emotional impacts on older women, particularly their confidence, is often identified as preventing older victims from disclosing abuse, seeking specialist support, or leaving. It is frequently acknowledged that the emotional effects were heightened when relationships were longer. There is a greater impact on survivors' confidence, self-esteem, and sense of identity. Consequently, older victims often require increased provision of support to help them achieve and uphold self-sufficiency.

Practitioners in Roger's and Taylor's (2019) study said that the longevity of relationships can impact on attempts to empower older victims to start a new life. Discussing empowerment, some DVA practitioners told me about their experiences of helping older victims take control of their lives. For instance, Rachel who offers outreach support talked about a recent case where an older survivor had gained control of her finances and now had her own phone:

> *"She's questioning leaving. She'd like to but it's a massive step because the longer you've been with somebody the harder it is. But she has taken one or two tiny steps - well, not tiny, they're quite big actually - simply getting control of her own finances, having her own bank account, which he didn't used to allow. And having her own phone that he doesn't know the code pass to get into it, because he always used to look at it."*

Similarly, Vivian discusses an older woman who accessed the refuge, who was now living independently:

> *"The older ladies are no different, they say they've had absolutely amazing support here and a recent lady, she's moved on and got a superb flat now, she's got it lovely."*

Despite the various overlapping issues older survivors face, and the acute impacts of victimisation, DVA workers identified how they can be empowered. Several DVA practitioners speak of older victims taking control of their lives by either starting a whole new life, or by gaining some control in their abusive relationships.

When victims told me their stories, an identified theme was their ability to take some control. Korine slept in her car because she hated being in a care home so much, Scarlett reported her son to the police (who is now in prison), Angus prevents further

abuse from her sister by putting the phone down on her and not going to see her anymore, Caroline has lodged a formal complaint against the care home, Ricky has taken legal action, Tegan, Joanne, Ellen, and Sharron all sought support to challenge social services, and Joan, May and Ricky all left their partners. Joan and Ricky managed to remove their partner from their home and remain there and May obtained her own place and is building a new life. All 13 respondents sought some support, albeit not always immediately, and all wanted to take part in the research because they wanted to effect change. By taking control of their own goals, mobilising informal and/or formal support, demonstrating their right to have a voice, and telling their stories with the aim of facilitating change, they demonstrate empowerment (Adams, 1990; Breton, 1994; Sullivan, 2016; O'Ocakli, 2019). My findings highlight this and additionally show how DVA professionals can empower older victims. In doing so, this promotes the idea that older survivors should be supported to manage their abusive situations in a way that suits them (Clarke et al, 2016; Wydall and Zerk, 2017).

Alongside a multitude of often intersecting factors, my findings reveal that the type of relationship between the victim and perpetrator can hinder older victims from ending abusive relationships and/or seeking support. This data is set out below.

7.3.4: Relationship between victim and perpetrator

Professionals from both groups (albeit mainly DVA workers) explain how the type of relationship between the victim and perpetrator can act as a barrier to leaving and/or seeking support. When the relationship is between partners and/or adult children, DVA practitioners said survivors are less likely to want to leave or *"cut off ties"* (Mia) with perpetrator(s). Instead, they *"just wanted the abuse to stop"* (Rachel). For example, Millie, a refuge support worker, told me about a case where an older woman was reluctant to stop seeing her children because *"you love"* them *"no matter what":*

> *"She would always tell you that you love your daughter and son no matter what. She just thought it's my job to look after them, and for her it was her moral and job to do that."*

Jennyren added how emotional involvement and dependency can make it harder:

> *"When it's children in particular, it makes it more difficult for the older person. I do find it's the emotional involvement. I can think of one family where the son*

delivered care. The parents were very dependent on the son, but he was taking their money and was controlling. They wanted the situation to change. But at the same time, they didn't want their children to stop caring for them"

The voices of practitioners in my study highlight how the type of relationship between the victim and perpetrator seems to impact on how older women respond to abuse. The acute difficulties survivors faced when victimisation was perpetrated by adult children was emphasised. Links are drawn to emotional impacts, and how the love for children acts as a significant barrier. As discussed in Chapter 5, the stories from the three victims who were abused by their adult children (Scarlett, Korine, Victoria) demonstrates that the emotional impact on them was significant. When this was compared to experiences of DVA committed by partners, or a sister (Angus, Ricky, May, Joan) the emotional impact was seemingly vocalised in a different way. The additional shame they experienced seemed to make it harder for them to stop seeing their adult child and impacted on their emotional recovery. The dynamics of offspring abuse is somewhat unlike partner abuse, as the bond and love between child and parent is different (Nguyen Phan, 2021; Smith, 2015; Smith, 2020; Solace Women's Aid, n.d). Therefore, it seems that when abuse is committed by adult children, it is experienced differently from when it is perpetrated by a partner.

7.4: Discussion

Consistent with past UK research (O'Keeffe et al, 2007; Naughton et al, 2010), a wide variety of violence and/or abuse is highlighted by my findings, from both groups of professionals. Nonetheless, social workers' experiences of working with older victims covers abuse that occurs in institutional settings and the community. One type, which was commonly discussed by social workers, in both settings was neglect. Similarly, past data indicates that neglect and acts of omission are the most common type of abuse experienced by older people (O'Keeffe et al, 2007; NHS Digital, 2018, 2019, 2020, 2021). When discussing this type of abuse, in institutions, respondents told me how cuts in services can lead to neglect, which supports observations by Burns and colleagues (2016). The voices of two victims in my study arguably further support this finding, as their stories indicate their belief that neglect in care homes is due to staff resourcing issues. From an analysis of the combined findings, I tentatively suggest that due to austerity, neoliberal ideology, ageist stereotypes and the undervaluing of

people with care and supports needs, the quality of care provided in care homes is impacted.

Irrespective of the setting, the least frequently discussed type by social workers was sexual victimisation. Sexual victimisation has been found to be the lowest type of abuse reported, in community settings and institutional settings (Naughton et al, 2010, O'Keeffe and colleagues, 2007, Yon et al, 2018). Although findings from DVA professionals in my study do not indicate it was the lowest type, it is impossible to generalise this result. Further, when compared to the other types of abuse DVA practitioners had experience of supporting victims with sexual abuse was the third lowest. Additionally, when the voices of the survivors who took part in my study are considered, it is possible to infer that reports of sexual victimisation are low. Taking my findings alongside past research, it is possible to suggest that sexual abuse of older women is not a frequent experience. Nevertheless, the low level may reflect barriers which make it harder for older women to disclose sexual abuse (Bows and Westermarland, 2017; Connolly et al, 2017) and does not necessarily mean they are less at risk.

Similarly, to past data (Acierno et al, 2010; Naughton et al, 2010; O'Keeffe et al, 2007; ONS, 2018), financial abuse was identified as a frequent type by both groups of professionals, and this also corresponds with the frequency levels disclosed by survivors in my study. However, these studies do not include the institutional settings. While it was clear findings from my victims and DVA professionals related to community settings, social worker respondents did not specify how this type of abuse might vary between institutions and community settings. Nevertheless, although financial abuse has not been as widely reported in institutions settings, it still occurs and is relatively common (Allen et al, 2003; Melchiorre, 2014; Saveman et al, 1999; Yon et al, 2018).

Victims and DVA professionals accounts indicate a few factors which impact on older victims' willingness to leave their relationship, and/or seek support. The importance of maintaining proximity to social networks and the thought of losing their home, seems to be a key factor preventing older victims from leaving their abusive relationships. It is suggested that the desire to remain in the home is more acute in comparison to

younger survivors because the meaning of the home and social networks is magnified in later life (Carthy and taylor, 2018; Rowles and Chaudhury, 2005; Tomini et al, 2016) Another key factor influencing older victims help seeking is when the abuse is committed by adult children. The additional shame mothers experience when their child is the abuser has been recognised previously, albeit not always by adult children (Nguyen Phan, 2021; Smith, 2015; Smith, 2020; Solace Women's Aid, n.d). Taking account of past literature, and by listening to survivors and practitioners' stories, it is feasible to suggest that the additional shame caused by the internal mandate to be a 'good' mum, is a significant barrier to seeking support when abuse is committed by adult children. Age and generational differences were also shown to present difficulties. Likewise, to past findings (Blood 2004; SaveLives, 2016; Scott and colleagues (2004), data from DVA professionals and two survivors in my study suggest that older women believe specialist services are only for younger victims. Additionally, in a similar vein to Bows (2017b) findings, DVA professionals and the women who took part in my research expressed a keen desire to change this belief by promoting awareness of victimisation against older women.

Various intersecting factors which impact on help seeking behaviour are identified, some of which have been recognised previously (ADASS, 2015; Blood, 2004; Bowen and Searle, 2019, McGarry and Simpson, 2010, 2011; SafeLives, 2016; Straka and Montminy, 2006; Teaster et al, 2006, Zink et al, 2003). These included increased vulnerability, invisibility, mobility issues, hearing problems, vision problems, isolation, a lack of confidence, financial considerations, living in rural areas, the length of time in the relationship, fear of change, and losing their home. Likewise, to Blood (2004), findings from DVA workers suggest that the consequences on confidence, self-esteem and identity is intensified when abusive relationships are longer in longevity. Consequently, often older survivors require additional support to help them take control of their lives (Roger and Taylor, 2019), thus suggesting that services might need to be delivered differently (Scoot et al, 2004; SafeLives, 2016). Empowering older survivors is often reported as successful, and the ability to be empowered was showcased by survivors' accounts. They mobilised support, took control of their own goals, and demonstrated their rights to have a voice by talking to me about their experiences (Adams, 1990; Breton, 1994; Sullivan, 2016; O'Ocakli, 2019). Support

given to older survivors should be tailored and help them manage their abusive situations in a way that suits them (Clarke et al, 2016; Wydall and Zerk, 2017).

Both services (albeit only one social worker) said that it was sometime difficult to encourage older women to accept DVA services because they had to break down barriers that services were only for younger women. Additionally, Ricky and Scarlett's comments arguably highlight a belief that services are only for older women. Taken together, my findings support previous literature which suggests older women are less likely to believe services are there for older women (Blood, 2004; Safelives, 2016; Scott et al, 2004). Likewise, to past findings (Bows, 2017b), DVA professionals in my study felt they had a responsibility to help change this by raising awareness. The desire to promote awareness was echoed by victims, who wanted to take part in my research because they hope their voices will help elicit change.

7.5: Chapter summary

This chapter has linked victims accounts with some of the findings from the two groups of practitioners, and has, when possible, connected with past research. Taking the findings from all three groups interviewed and making comparisons provides a further analysis of the nature and impact of violence and/or abuse against women aged 60 and over. By bringing attention to the voices of people who have experienced violence/and or abuse, or worked with those that have experienced it, this chapter has helped cast light on the types of violence and/or abuse older women experience, and the various factors which impact on help seeking behaviour and the support they require.

Chapter 8: Conclusion

8.1: Introduction

There has been limited attention paid to violence and/or abuse against older women (Bows, 2019a). Despite calls to listen to the voices of survivors (Blood, 2004, Carthy and Taylor, 2018; Fileborn, 2016; Hall, 2014), the lived experiences, voices, wishes, needs and rights of older people has been largely overlooked (Wydall et al, 2019; House of Commons Health Committee, 2004). When research has been carried out it is mainly limited to heterosexual partners living in the community (Lazenbatt et al, 2013, 2014; Mc Garry and Simpson, 2010, 2011; Scott et al, 2004; Yon et al, 2018), or there is a failure to analyse the possible differences in survivors' experiences (Mowlam et al, 2007; Naughton et al, 2010; Pritchard, 2000). There is also a dearth of studies exploring how DVA organisations and adult social services respond to older victims and the challenges they face (Bowman and Searle, 2019; Carthy and Bowman, 2019).

Victimisation against older groups is a multifaceted issue (Hall, 2014). However, understandings of this phenomenon mainly emerge from a social care and vulnerability perspective, which focus on age (Meyer et al, 2020; Penhale, 2003; Scott et al, 2004). It is essential to move away from this and consider gender inequality, ageism, (Nerenberg, 2002) the intersection of various factors and characteristics (Help Age International (HAI), 2017a), because these set the context for abuse to occur and can prolong exposure to it (Penhale, 2003). An intersectional feminist framework, as informed by social constructionism achieves this as it enables an exploration of various inequalities including gender, age, and ethnicity and draws attention to the root causes of abuse (Burgess-Proctor, 2006; Crenshaw, 1993, Hall, 2014; Nash, 2008).

By meticulously presenting my findings in a manner that allows for identification of differences between experiences of violence and/or abuse against older women, by a range of perpetrators, and in different settings, this doctoral research sought to address the gaps in current research. I highlight the lived experiences of survivors who disclosed DVA and NDA, and attempt to show how power operates across different types of abuse, and in different settings. In doing so, I contribute a more

nuanced understanding of violence and/or abuse against older women. I have also added to the small body of literature that considers the challenges social services and DVA professionals face when working with older survivors (Carthy and Bowman, 2019), and advanced previous findings concerning the types of interventions they initiate (Yechezkel and Ayalon, 2013).

This final chapter presents the main findings from the empirical research I conducted with survivors, and practitioners. It provides a summary of these and discusses them in relation to the research questions and aims. It outlines priorities for future research and implications for policy and practice. The key contributions to knowledge are set out, and reflections on the research are provided.

8.2: What is the nature and impact of violence and/or abuse against women aged 60 and over?

8.2.1: Summary of findings

This section aims to demonstrate how the findings help advance knowledge regarding the nature and impact of violence and/or abuse against women aged 60 and over. To do so, it presents the main themes that derive from the interviews conducted with 13 older women, who self-identified as experiencing violence and/or abuse after the age of 60 and how these correspond to past literature. To facilitate a higher analysis, this section also sets out the findings from the 21 interviews with professionals, which highlighted the nature and impact of violence and/ or abuse on older women.

Types of violence and/or abuse

Likewise, to past UK research (O'Keeffe et al, 2007; Mowlam et al, 2007; Naughton et al, 2010), a wide variety of abuse was revealed which included DVA and NDA. In relation to DVA the types included emotional, physical, financial, and coercive control. For victims of NDA, the types they told me about were financial, age and gender discrimination, verbal, emotional, neglect, and sexual touching. Additionally, various types of abuse were discussed by both groups of professionals in my study. These were physical, sexual, financial, emotional, verbal, coercive control and neglect (albeit coercive control was only discussed by DVA workers, and neglect by social workers). Social workers also told me about different types of NDA.

The stories of two women who told me about coercive control help advance knowledge beyond studies already conducted. Past studies that consider coercive control are restricted to heterosexual relations only, (Policastro and Finn, 2015; Sprangler and Brandel, 2007, Wydall et al, 2017). Thus, when family members are the perpetrators of this type of abuse, there seems to be an absence of knowledge of how this is experienced. Scarlett describes how her son frequently damaged her property and/or physically attacked her if she refused to give him money and/or let him reside with her. Angus explains how her sister used threatening language, bullying, and verbal abuse to make her hand over money. While these findings cannot be generalised, these two accounts start to unpick how coercive control manifests in family relationships.

Mowlam and colleagues (2007) helped draw attention to some of the different types of NDA that older survivors experience. Their findings showed how some older people had difficulties when being assessed by social services and how these were sometimes seen as comparable to abuse. However, they did not offer an analysis of how shame, and negative stereotypes could be used as a potential method of control by practitioners in social services. Tegan, Ellen, Sharron, and Joanne told me about their experiences with social services. They described several incidents during the process of having their care and support plans reviewed where professions from social services bullied and intimated them. An analysis of their stories suggests that shame, and the negative stereotypes associated with age and disability were used as a tool to make them suppress their needs for care and support. I further suggest that their experiences were seen as tantamount to coercive control. Coercive control is a criminal offence when it is committed in intimate relationships (past or present) or between family members (SCA, s76(2)). Although, I do not suggest widening the criminal definition, to include wider perpetrators, these four stories open a valid debate about how the acts of professionals might be seen as controlling and coercive.

Abuse by adult children

Research exploring adult child to parent abuse (ACTP), particularly in the UK is very limited (Holt and Shon, 2018). My findings help advance this knowledge because they provide descriptive details of abuse by adult children. Scarlett told me about several incidents her adult son exposed her to. This included physical abuse, emotional abuse and damaging her property. Korine told me about a mix of financial abuse and emotional abuse committed by her three children, and Victoria described financial abuse. Despite the differences in how these types manifested, all three respondents said they were reluctant to disclose their abuse because they felt embarrassed that people might think they were unfit parents. This finding thus seems to support Smith's (2020) conclusions that older mums are impacted by the internalised mandate of being a 'good mum' and experience guilt when this ideology is not met. It also carries hallmarks of Nguyen Phan (2021) unpublished research who found that abuse committed by committed by children (albeit mainly for child to parent violent) is impacted by socially constructed notions of being a good mum. Although my research is focused on older women, by supporting Nguyen Phan (2021) findings, arguably I also help strengthen her claims that CTP and ACTP have comparable impacts. However, the participants in my study also told me that their age impacted on their willingness to seek support. They believed that society would judge them more because they should have got parenting 'right' by their age. This, thus, indicates that older women might experience additional shame when they are abused by their adult child. However, I do not thus suggest that their experiences should be termed elder abuse as a result. By supporting claims that CTP and ACTP have similar impacts (Nguyen Phan, 2021), instead I believe I help establish that there is no use in calling older women's experiences elder abuse, because it seems that irrespective of age, the shame caused by being abused by children is similar.

When describing abuse by adult children, another common theme was emotional impacts. All three respondents told me how they were heartbroken or devastated. The emotional impacts vocalised by older survivors who explained abuse by their partners or sister seem to be vocalised differently. Observations by Solace Women's Aid (SWA) (2016) suggest that when children are perpetrators, older survivors experience additional shame and guilt because they believe they are failing to meet socially

constructed notions that families provide love and warmth. I tentatively suggest that as a result they may vocalise their experiences in different ways than women who have been abused by their partners. It seems that the complex laying of gender, age, and socio-cultural expectations about families, shape their emotional responses.

Abuse in care homes

Two respondents told me they experienced neglect whilst in a care home. They both described how they had been ignored by care staff, and Caroline also told me how there was a failure to assist her with required daily exercises to keep her mobile. A common form of abuse that social workers told me about was neglect in care homes, which included people not receiving adequate care. Although research exploring how abuse in care homes manifests is limited (Hawes, 2003; Yon et al, 2018), it is not wholly absent (Ludvigsson et al, 2022). The different descriptions of neglect from my findings helps add to this past Swedish study, which highlighted issues around meeting hygiene needs and insufficient assistance with buying food or medication. However, as discussed later, both survivors in my study and professionals seem to suggest that the blame for neglectful acts is due to systemic and organisational issues that stem from austerity. As such, an analysis of my findings moves beyond the past research.

Additionally, Caroline described how another resident had exposed her to sexual touching of himself and Maria (a social worker) discussed how many residents in care home display 'heightened sexual activity'. While she did not define this type, it was suggested that this is when people sexually touch themselves without meaning to and drew attention to how many people have dementia. Caroline also acknowledged the interplay of dementia. She also believed his acts were sexual and aimed at her. It is however feasible, she misunderstood his genital touching as sexual, when instead it was due to pain or discomfort (De Giorgi, 2016). Ludvigsson and colleagues (2022) also reported sexual abuse in care homes, and provide details of one experience, which was a member of staff making sexual invitations to an 84-year-old woman. The combined analysis of Caroline and Maria's adds to this by detailing an experience committed by another resident, and by showing the scope of possible

misinterpretation given the complex interplay of age, vulnerability, and people with dementia.

Experiences of violence and/or abuse (a multifaceted issue)

The voices of the 13 older women interviewed highlights how violence and/or abuse against older women is a multifaceted issue, heavily contingent on social understandings and dictums, rules and expectations. A range of inequalities and multiple factors shape experiences of abuse and responses to it. There are individual and systematic factors (Penhale, 2003). My findings showcase how this includes age, generational differences, established patriarchal norms, shame, physical disabilities, mental health difficulties, ill health, dependency on perpetrators, perpetrators dependency, fear of being alone, finances, not wanting to lose their home, concerns of losing vital social networks, living in a village, and experiences of abuse prior to turning 60. These often combine and hinder help seeking behaviour and/or leaving relationships. However, the findings suggest that combination of gender, age, ageism, and disability are particularly powerful in causing shame and preventing disclosure.

Ricky's story brings attention to the changing nature of power and the various features that affected her decision to remain in her abusive relationship. Due to affluence and education, Ricky held some power in her relationship. This power balance altered over time and was impacted by her partner losing his power and status in society. This, arguably, led to a perceived need to reassert his masculinity and use additional measures (physical violence) to exert control. Her position of power and oppression, alongside other factors, seemingly influenced her decision to remain in a risky relationship and willingness to seek support. I suggest that Ricky's reluctance was linked to these intersecting identities, age, shame, living in a rural location, and fear of going against established patriarchal norms.

Likewise, to Bowen and Searle (2019) findings, practitioners identify a range of issues that hinder older women from seeking support. These reflected those disclosed to me by victims, and include age, vulnerability, mobility issues, isolation, a lack of confidence, financial considerations, living in rural areas, fear of change, and losing their home. Professionals told me that older victims are less aware of services or fail

to understand they can access them at their age. Ricky told me she was shocked at what support was available, and Scarlett thought DVA services were just for younger women. Taken together the findings support previous research which suggests older women are less likely to know about services or believe they are there for older women (Blood, 2004; Safelives, 2016; Scott et al, 2004).

Losing the home and vital networks was a key barrier

Ricky and Joan stories showcase how losing their home and social networks was so inconceivable that they remained in their risky relationships. My research seems to be the first empirical study to record this from a victim's perspective and thus moves beyond past research. Although this finding cannot be generalised, it helps to unpack how the meaning attached to older survivors' homes and the importance of maintaining proximity to social networks is a key barrier preventing older victims from leaving their abusive relationships. Several DVA workers told me that often, when they work with older survivors, they worry about what they will lose, especially their home. This combined with how their whole life has usually been spent in a community where they feel safe and secure, causes them to accept their abuse and remain in risky relationships. Likewise, in a study by Carthy and Taylor (2018) and another by Bowen and Searle (2019) professionals expressed their beliefs that a significant factor preventing older women from leaving their partners is the thought of leaving their homes. It is unclear if this was just their perception or based on knowledge gained from supporting older victims. To some extent my findings thus go beyond this as the professional in my study were clear that their stories derived from their experiences of supporting older survivors and were not just based on their own personal views. The combination of findings from survivors and professional in my study, and past literature suggests that losing the home and vital networks is a key barrier which prevent older victims from leaving their abusive situations.

Accessing support

All 13 participants gained formal and/or informal support. However, all respondents' help seeking was impacted by shame, in various ways which initially prevented them from seeking support. As noted earlier, the three participants who were abused by their adult children did not seek help immediately due to the shame if being seen as a

‘bad’ mother, at their age. The different factors that impacted on Ricky, including shame were detailed earlier. Likewise, for Joan, May, and Angus a variety of factors, alongside shame seems to have prevented them from initially accessing support.

For the four respondents who describe abuse by social workers as abuse, they initially did not pursue any support to help them challenge decisions regarding their care and support packages. No assistance was sought by Ellen for four years, Sharron waited two years, Joanne took three years, and Tegan reached out after two and a half years. They describe how they felt too ashamed and powerless to ‘fight’. Stevens (2017) who is a long-term service draws stark attention to how many users do not have the *“knowledge, experience or weaponry to fight the system and win”.* The stories I share emphasise this to some extent. Their accounts also show an absence of free formal emotional support for NDA victims. Given the impacts on them, it is unclear how this can be justified. In contrast, reflections on DVA services were all positive and the account from DVA practitioners and one social worker (Ellie) suggests that when older women access specialist services they benefit. There was no indication of ageist responses from DVA professionals, but it must be borne in mind that they may have masked stereotypical views to protect themselves and their organisation. As discussed later however, social workers' responses to older victims seem to be grounded in ageist views.

The need to promote awareness

Data from professionals (mainly DVA professionals) suggests there is a lack of awareness that services are also available for older women experiencing DVA. This posed a challenge because they had to break down these barriers to encourage older victims to accept support. Additionally, the narratives of two older women respondents arguably highlights a belief that services are not for older women. Ricky told me she was shocked at what support was available, and Scarlett thought DVA services were just for younger women. Taken together the findings support previous research which suggests older women are less likely to believe DVA services are also available for older women (Blood, 2004; Safelives, 2016; Scott et al, 2004). Likewise, to past findings (Bows, 2017b), DVA professionals in my study felt that they were responsible for raising awareness of services. In doing so, they hoped they could promote change.

Likewise, the desire to promote awareness was echoed by my victims, who wanted to take part in this research because they hoped their voices will help elicit change.

Empowerment

Due to the length of time, they have spent in relationships, whereby they have usually never had any control over financial issues, empowering older victims has been found to be particularly difficult (Roger and Taylor, 2019). However, some DVA professionals told me how they had helped empower older victims. Additionally, survivors displayed empowerment by taking control of their future, mobilising informal and/or formal support, demonstrating their right to have a voice, and by telling their stories with the aim of facilitating change (Adams, 1990; Breton, 1994; Rappaport, 1987; Sullivan, 2016; Ocakli, 2019). DVA workers report how older survivors can be empowered and take control of their lives. Thus, my findings arguably support Clarke and colleagues (2016), and Wydall and Zerk (2017) conclusions that it is essential to provide older victims with choice and control over the services they receive. They can and do display empowerment and this should be encouraged.

Austerity, neoliberalism, ageism, and the undervaluing of people with care and support needs

When telling me about the treatment by care workers, two victims' narratives show they did not think it was the fault of care staff. Two social workers somewhat mirrored their views, that when neglect takes place in institutions, it is not the fault of staff. Both professionals drew attention to the difficulties of providing adequate care and standards which they attributed to the current financial climate. Previous literature suggests that due to austerity there has been a chronic underfunding of the social care sector (Bawden, 2017), which has arguably impacted on the quality of care in care homes (Burns et al, 2016). The rhetoric of neoliberalism (Culpitt, 1999) also impacts on the quality of care given in care homes because under this doctrine, people with care and support needs are not seen as bringing value to society (Chisnell and Kelly, 2019). This impacts more on older people because more older people have care and support needs and are also seen a 'burdens' on society. The combination of my findings thus suggests that due to austerity, neoliberal ideology, ageist stereotypes

and the undervaluing of people with care and support needs, the quality of care provided in care homes is impacted.

Austerity, neoliberal ideology, and the undervaluing of older people and those with care and support needs, was arguably evident in Ellen's narrative. Likewise, Ellen did not feel her abusive situation (which was potential age and gender discrimination), committed by domiciliary care workers was their fault. Instead, she blamed it on a lack of education and training. Arguably as result of chronic underfunding in the social care sector (Bawden, 2017), care workers are frequently recruited without an understanding of how they should respond to people (Ravalier et al, 2019), and are provided with limited training (Unison, n.d). Although Ellen's experience presents as atypical, it helps shed light on the impacts of austerity, neoliberal ideology, ageist stereotypes and the undervaluing of people with care and support needs.

Chisnell and Kelly (2019) have observed that due to austerity, and neoliberalism, a discourse is propagated around the need to save money, whereby the reduction of care and support packages becomes legitimised. They argue that as a result social workers might be disingenuous when assessing the needs for care and support. My findings move beyond this by describing how four respondents believed their treatment by social services was abusive. As detailed previously, they described their actions as bullying, intimidating and an analysis of their narratives suggests these acts were seen as tantamount to coercive control. As the rhetoric of neoliberalism reinforces ageism and the undervaluing of people with care and support needs (Ward et al, 20020), I cautiously suggest that the combination of ageism, undervaluing people with support needs, austerity, and neoliberal ideology, promotes and creates an environment for abuse against older women.

My findings show that victimisation committed by professionals has similar impacts when compared to the consequences for DVA survivors, but shame is arguably increased for older disabled women experiencing NDA. This highlights the importance of moving away from understandings of victimisation that mainly focus on individuals in intimate relationships. Further, all four respondents self-identified as disabled, older women who were vulnerable. I contend that the way age, disability, and vulnerability are constructed in society, caused a heightened sense of shame. Their sense of shame is arguably reinforced by austerity and neoliberal ideology which gives rise to

the idea that older people and people with disabilities are somehow less worthy because they are burdens on the state (Ward et al, 2020).

8.2.2: Priorities for future research

To help address the gaps in my research further empirical studies are needed. While my findings offer a more nuanced account of violence and or/abuse against older women, the findings are not generalisable, and some gaps remain. It is essential to build on this so that a fuller picture can be obtained. Studies need to explore:

- Violence and/or abuse of older women from minority groups, including BAME, LBGT, people that identify as non-binary, migrant women, refugees, people with disabilities, and women from travelling communities.
- Violence and/or abuse against older women in different locations, especially villages, with a view of exposing how geographical location intersects with their experiences.
- Coercive control between family members.
- ACTP violence and/or abuse.
- How the actions of professionals from social services, when carrying out care and support assessments are interpreted as abusive, and what support could assist emotional recovery.
- Provision of care, by care workers and the extent this is seen as abusive. It would be useful to further explore how this is linked to increased risk due to intersecting inequalities, and the impact of austerity, and neoliberalism.
- Abuse in institutional settings. It is recognised that gaining access to participants is fraught with difficulty, and raises ethical challenges (Suhonen and Stolt, 2013). But ‘vulnerable’ people have equal rights to participate in research, and thus solutions to challenges should be sought.
- How neglect and standards of care, in care homes negatively impacts on older residents’ quality of life, and what is needed to resolve this.

8.2.3: Implications for policy and practice

There are several implications raised. These are as follows:

- Due consideration should be given to introducing free support for survivors of NDA to assist them in coping with emotional consequences. There seems to be no voluntary services offering interventions to assist NDA survivors to recover emotionally, increase their confidence, cope with depression, and decrease their sense of shame and feelings of worthlessness. It is unclear how this can be justified.
- Address standards of care in care home and home care support. It is essential to provide the necessary funding to improve older people's quality of life and prevent abuse against them.
- Address the issues that foster and create an environment for abuse against older people. This includes undervaluing individuals with support needs, ageism, austerity, and neoliberal ideology.
- Ensure older victims are provided with choice and control over the services they receive.
- The belief older people do not suffer abuse, particularly DVA needs challenging, with the aim of transforming views. Awareness building needs to break down attitudes which condone violence and/or abuse against older people. It is suggested this could take a similar approach to the early feminist movement which changed the political and legal landscape for DVA, and helped changed public attitudes (Houston, 2014). However, unlike early feminism, this would need to acknowledge and address the impact of age and ageism (Penhale, 2003), not just gender. More media campaigns would be beneficial, and awareness events should be held in places where older people are more likely to go as this is likely to improve survivors' willingness to engage with services (Blood, 2004). Financial and other resources are required for such outputs, which ideally should not be left to the uncertainty of gaining funding. It is contended that more financial support and endorsement is required at a political level to facilitate the changes required to reduce, prevent, and respond more effectively to violence and/or abuse against older people. Without a change to austerity measures, and a move away from neoliberal policies it is difficult to see how this can be achieved.

8.3: What can the experiences of professionals from social services and DVA organisations tell us about violence and/or abuse against older women?

8.3.1: Summary of findings

This section presents an overview of the main findings from the 21 interviews conducted with practitioners from two distinct fields of practice, DVA professionals and social workers. Unless otherwise specified these findings relate to both groups of professionals.

Ability of services to respond effectively

17 professionals' expressed confidence issues in recognising violence and/or abuse against older women. Confidence in recognising this phenomenon seems to be impacted by a lack of specific training. Although most practitioners want specific training, all 21 participants said there is an absence of it. They suggest that without it, they might initially find it hard to comprehend older people are victims. My findings thus support Carthy and Bowman (2019) conclusions that an absence of training leaves practitioners with little or no concrete knowledge to draw on to reliably inform their working practices. Without training, effective responses are contingent on professionals gaining enough experience. Given the number of older victims accessing DVA organisations is low, this may not always be possible. While social services work with more older victims, the stories I shared indicate they are not effectively equipped to respond to DVA survivors. Before proceeding, it is imperative to note that the accounts given by social workers suggest that their practices conform to the medical approach. This stance focuses on what is 'wrong' with individuals, (Shakespeare, 2017) and impacts on older people more because they are seen as inherently vulnerable (Lonbay, 2018). Notions of decline and vulnerability underscore stereotypical ideas of old age (Jones et al, 2006; Pritchard-Jones, 2016). Their practices are arguably therefore grounded in ageist views. This alongside a lack of training affects their ability to recognise and respond to older victims.

Maria and Beryl discuss DVA training, both were managers, but only Beryl said she ensured her staff gained the relevant training to understand the intricacies of DVA and what agencies can help. An alarming eight of ten social workers have not received

any formal DVA training, but Ellie attended a seminar specifically focused on sexual abuse against older women. She is the only social worker respondent to discuss referring an older woman to a refuge. Jessica describes spending a year and a half working in a refuge, as part of her placement. She provides a clear distinction between how social services and DVA organisations approach a refusal to engage with support, which I return to later. She also told me that unless you work in children's social care, DVA training is not mandatory. This is inferred or confirmed by all ten social workers. An absence of DVA training is highlighted by McLaughlin (2018), and thus it seems this is commonplace. A lack of compulsory training reinforces the construction of DA as a child protection issue, which acutely impacts on older women because they are less likely to have dependent children (Robbins et al, 2016). It can also affect their ability to identify DVA because it reinforces ageist views that assume DA only affects younger women (Peckover, 2007). The dearth of knowledge and ageist assumptions are concerning. Yechezkel and Ayalon (2013) found that social workers are far less likely to identify intimate partner abuse (IPA) when survivors are older (Yechezkel and Ayalon, 2013). A failure to identify DVA impacts on prevalence data which adds to the systematic invisibility of older survivors (Safelives, 2016; Wydall et al, 2015). This can subsequently impact on service developments (Bows, 2019a), and be used to justify a lack of specific mandatory training.

A lack of training seems to prevent social services from referring to specialist support. Pink, a DA support worker, explains a situation where social services were involved for some time, but only made a referral after an older victim suffered a serious physical attack, which resulted in police intervention. The police insisted more could be done, and thus it seems a referral was only instigated because of police involvement. An earlier referral could have potentially prevented the physical harm. Further, the voices of social workers themselves infer that due to a lack of knowledge and perceived notions of vulnerability, they do not refer to specialist organisations when DVA is disclosed. Instead, they only focus on the individual's care and support needs and use social care interventions. These are wholly inappropriate because they do not minimise risk of DVA, and they do not address power and control dynamics. This is concerning because risk of serious injury or death is increased when older women are seeking help or leaving an abusive relationship (Brandl, 2000).

Anna's account demonstrates she believes DVA may stem from carer stress. This leads to victim blaming, and interventions are often only put in place for the carer, not the victim (Wydal et al, 2018). This can be fatal as risk is not minimised (Sharps-Jeff, 2016). In comparison, DVA workers recognise the need to tailor interventions. They show consideration of care and support needs, and a multitude of intersecting factors which might impact on older survivors. This includes how much empowerment they need and the length of time they had been in their relationship. It is additionally acknowledged that to empower them, knowledge is required to support them, and confidence is needed to build their self-esteem. This reinforces my previous contentions that training is essential to effectively support older victims. My findings support Carthy and Taylor (2018) findings that adult social services are not always equipped to effectively deal with DA in later life, and Sharp-Jeffs and Kelly (2016) conclusions that adult services need to be trained to understand the unique dynamics prevalent in DA cases.

Only one social worker (Ellie) referred an older woman to a refuge, but she does not say she worked with them to develop a support plan. It is implied that once the referral was complete, her role ended. Three DVA professionals said some referrals to their agencies are from social services, albeit rare. When this did occur, issues are highlighted. Jennyren for instance explains one case where social services were involved that seems more like a case handover than working together. Working with adult social services was implied as necessary to facilitate developing effective support plans for older victims with care and support needs. Similarly, to Blood (2014) and SWA (n.d) the importance of DVA organisations and adult protection working together to develop packages of care that reflect the needs and wishes of older victims with community care needs is highlighted.

Challenges services face

Information sharing was emphasised as a key issue. Practitioners are fearful of breaching General Data Protection Regulations (GDPR), which prevents disclosure of information. This fear is enhanced when organisations are out of area, or information is requested over the phone. When professionals have personal contacts or prefer disclosure over non-disclosure, issues are mitigated. Somewhat similarly, (Wydall et al, 2015) provide evidence that practitioners are uncertain about formal

data sharing protocols, which is a potential barrier in providing effective support for older victims. I cautiously argue that information sharing presents additional challenges when trying to gain data for older victims. Disclosure is only permissible when the requested information is relevant (GDPR, article 5, 1c). SafeLives (2016) findings show that some professionals do not believe older people can experience DA. If they were asked to disclose information on an abused older person's situation, it is feasible they would fail to see the relevance and consequently refuse to provide data. This could cause services difficulty when trying to gain data from individuals, who hold stereotypical views. This postulation is not substantiated by the current findings and is arguably worthy of further investigation.

Further, social workers said that the right to make *'unwise'* decisions could present challenges and inferred this was an impasse to providing support. No DVA practitioners discuss mental capacity, but one social worker (Jessica) told me about her previous experiences of working in a DVA organisation. She compared this to the approach taken by social workers when victims refuse support, saying DVA services continue to inform them of their options and offer support. This supports Wydall et al (2015) findings that practitioners who understand power, control and coercion are more likely to support an approach that asks more questions, seeks more details, and intervenes. My findings also shows how a lack of awareness of DVA impacts on social workers ability to judge if a refusal to accept support is based on undue influence or autonomy. Given research indicates DA survivors are often unable to provide consent for interventions because they are unduly influenced by perpetrators (Hoyle and Sanders, 2000), concerns are raised. Consequently, a refusal to accept support should never be seen as a reason to do nothing (Robbins et al, 2014), yet this seems to be the approach taken by some social workers.

Another challenge raised was age. Likewise, to Carthy and Bowman (2019), age is perceived as hindering disclosure when professionals were younger, but as an attribute when they were older. Additionally, Jenny, a DVA practitioner said the age of victims can cause issues because they are more likely to be accompanied by perpetrators, which impacts on the ability to talk to them and offer support (SafeLives, 2016). Age also had the potential to affect the effectiveness of DASH. All DVA workers comment on its lack of suitability for assessing risk because there are some questions

that are less relevant for older survivors and/or the wording may cause shock. Attention is drawn to how this is mitigated by either framing certain questions in a different way or using their professional judgement to ensure cases were heard at multi-agency risk assessment conferences (MARAC). Although DASH was identified as having setbacks, most DVA practitioners said it was a useful tool, and how it could be utilised to help older survivors identify they had been abused. In contrast, social workers rely on inhouse tools to assess risk, even for DVA enquiries. Evidence that social workers either avoid, or do not use DASH is provided by past research (Clarke et al, 2012; Wydall et al, 2016). Further, as discussed in Chapter 2, the avoidance of using DASH is arguably reinforced by the framework they are provided with to assess risk (Social Care Institute for Excellence (SCIE, 2020a). A failure to use DASH is problematic because it can have fatal consequences (Sharp- Jeffs and Kelly, 2016). It also contributes to the systemic invisibility of older DA victims (SafeLives, 2016, Wydall et al, 2018). By failing to use DASH the practice of social workers arguably helps reinforce the idea that older groups do not experience DVA and places them at significant risk.

The impact of austerity and neoliberalism

One social worker discussed how *"cuts"* have led to challenges in service provision which includes a lack of specific services for older victims. The loss of a specific team dealing with older people is articulated by Isobel who felt the previous set up was better because she could focus more on older people's needs. The amalgamation of teams within social services has become commonplace in a time of austerity (Cooper et al, 2018; Robbins et al, 2016). This is concerning because it prevents the ability to build relationships of trust and prevents disclosure (Blood, 2004, Carthy and Bowman, 2019; Lewis and Williams, 2015; SafeLives, 2016; Scott et al, 2004).

DVA professionals commented on the lack of services and limitations to current services and linked this to austerity. 'Cuts' were perceived as affecting older survivors more, for a variety of reasons. This includes, increased isolation, poverty, transport issues, disability, health needs, and loss of confidence. These barriers have been highlighted by previous research and observations (ADASS, 2015; Blood, 2004; Bowen and Searle, 2019, McGarry and Simpson, 2010, 2011; SafeLives, 2016; Straka

and Montminy, 2006; Teaster al, 2006, Zink et al, 2003) but not from an austerity perspective. My findings thus help highlight how barriers older survivors face are now additionally impacted by the current climate, and thus show how the power at a wider political level can have negative consequences for victims.

The impact of the current financial climate was also demonstrated when DVA professionals discussed implementing provisions that might benefit older victims. Likewise, to previous studies (Blood, 2004; Carthy and Taylor, 2018), several DVA practitioners said older women struggled in refuges due to noisy children and/or they were unable to cater for their care and support needs due to a lack of amenities to meet these needs. There is a desire to remedy this by creating separate annexes, but an acknowledgement this required resources that are not readily available due to a lack of funding. This draws attention to the issues of funding and supports previous contentions that developing and/or sustaining such projects in the current financial climate is challenging (SWA, n.d).

8.3.2: Priorities for future research

Future research could explore:

- How many cases of DVA social workers investigate and examine the extent this, alongside other factors, impacts on their ability to effectively recognise and respond to older victims.
- The extent that policies, practices, and procedures ignore the needs of older women. I return to this in section 8.5.
- Explore the impact of coercion on traumatised individuals and how this intersects with assessing mental capacity.
- Examine the difficulties relating to information sharing with particular focus on whether these are exasperated when trying to gain data for older victims.

8.3.3: Implications for policy and practice

There are several implications raised as follows:

- Services should receive training that takes an intersectional approach which covers the multiple barriers and increased risk faced by different groups. A

focus on older people's experiences and their specific needs, alongside challenging institutional ageism needs to be included.

- Specific DVA services and support for older survivors should be more readily available, additional outreach services should be established. Financial help from Government is essential to facilitate developing these.
- Thought should be given to reinstating a separate team within social services for older adults.
- Irrespective of the team they work in, it is essential that professionals within adult social services, who might encounter older survivors, gain specific training on the dynamics of DVA, identification, and risk assessment (Sharps-Jeffs and Kelly 2016).
- Services should adopt an intersectional approach when working with older survivors. Services that take an intersectional approach are better positioned to acknowledge how experiences of DVA or NDA are not ground in one identity marker (eg, age or gender), they are problems that are impacted by various intersecting inequalities, and structural issues, such as policies, priorities and strategies that often disregards the specific needs of many women (Crenshaw, 1991). An awareness of how multiple factors impact on experiences of abuse, as well as the barriers to help seeking, helps provide insight into appropriate interventions (Bernard, 2020; Crenshaw, 1991, 2003). It also offers a way for practitioners to build strengths-based relationships with survivors and empower them (Bernard, 2020, Chaplin et al, 2019).
- Social workers are well placed to provide an effective service to older survivors (Robbins et al, 2016), but there needs to be a clear commitment to resource a significant shift in practice. As detailed above this includes providing them with specific training and taking an intersectional approach when working with service users (both DVA and NDA).
- When older victims have care and support needs and are experiencing DVA, there is a need for social services to work with specialist services and share their expertise in dealing with complex care and support needs.
- A common practice to involve other relevant agencies should be established to help facilitate effective interventions to reduce risk and support survivors in the way they choose. This includes working with criminal and civil justice

professionals to enable older victims to pursue legal justice and/or remedies (Clarke et al, 2016).

- It is evident that there are differences and similarities between EA and DVA (Penhale, 2003). I propose that to avoid the conceptual difficulties caused by the two terms, and the negative impacts this presents, the term EA should be avoided. Instead, when older women experience DVA it should be called this, and when abuse is, for example experienced in a care home, or a neighbour commits it, the term I use, NDA could be adopted. This has the clear advantage of separating these two types of abuse and may help avoid DVA experienced by older people from being classified and treated as EA. This helps ensure appropriate responses are put in place. While this might be useful, as NDA can occur in community settings and institutions, the groping together may cause issues. Research and investigations would thus need to be carried out to examine how to frame this in a way that avoids confusion, and reduce the chances of implementing inappropriate policies, practices and procedures. Any explorations should consider the role of power (Penhale, 2003; Spangler and Brandl, 2007), how it is influenced by wider systematic and organisational issues, and consult with and include the victims of NDA, for example by conducting co-produced research (Ward, 2020).

8.4: Contributions to knowledge

The voices of older women who have been victimised have been somewhat ignored (Bows, 2019a). Studies that have incorporated the voices of victims are mainly restricted to DVA between heterosexual partners living in the community (Lazenbatt et al, 2013 & 2014; Mc Garry 2010 & 2011; and Scott et al, 2004). When wider victims, perpetrators, and settings are included, there has been no analysis of the possible differences in victims’ experiences, or what diverse factors might hinder disclosure (Mowlam et al, 2007; Naughton et al, 2010; and Pritchard, 2000). By listening to a range of experiences, this study makes an original and valuable contribution to feminist criminology and victimology.

A few key advances are evident. I reveal experiences of coercive control outside of IPV contexts, provide rich details of abuse in care homes, NDA that is committed by practitioners form social services, and added a feminist perspective to the small pool of research carried out in the USA (Smith 2015) which considers abuse committed by adult children against older women. Moreover, my findings seem to be the first to showcase older victims' voices that indicate how the meaning of the home and vital social networks combine to make them less likely to want to leave their risky relationships. Additionally, despite recognition that it is essential to empower older victims (Clarke et al, 2016; Ocakli et al, 2019; Wydall et al, 2017), past studies do not seem to provide examples of how older survivors can take control of their own goals, and demonstrate their right to have their say, with the aim of effecting change. I detail the ways all 13 older survivors demonstrate empowerment. I hope by sharing this, there will be greater recognition of the power older victims can and do display, which facilitates moving away from stereotypical views that they are inherently vulnerable (Clarke et al, 2016; Lonbay, 2018). Further, by describing the experiences of practitioners and emphasising the challenges they face I contribute to past findings (Bowen and Searle, 2019; Carthy and Bowman, 2019), but add originality by considering the impacts of austerity and neoliberal ideology. I have also provided evidence that social workers manage DVA cases by using social care interventions. While some professionals imply, social works do not always refer to specialist organisations (Wydall, 2015), my findings derive from the voices of practitioners from social services themselves.

There has been an absence of engagement with feminist theories and no published studies employ an intersectional feminist framework (Bows, 2019a). Consequently, the uniqueness of my project can be seen in the methodology adopted. By listening to the voices of survivors and practitioners, the findings help build a fuller picture of the nature of violence and/or abuse against older women, and the various intersecting factors that perpetuate abusive situations and act against their resolution. This helps build an understanding of various individual and systematic factors that increase risks and prevent help seeking.

8.5: Reflections on research

The method used to gather data was un-structured interviews. Chapter 4 provided a critical evaluation of this. While I still believe this was the most appropriate method to gain data from survivors, if I explored professionals' experiences again, I would use a structured or semi structured interview schedule. It was unclear how many enquires of DVA, and NDA social workers have investigated. Consequently, I could not rule out the extent, a lack of experience (alongside ageism, not using DASH, lack of training, and the cultural beliefs that DVA is not a safeguarding matter) influenced their responses to DVA. Employing a structured or semi structured interview guide is more likely to gain the required data, because they promote a focus on set topics (Sarantakos, 2013). I also wanted to reveal the extent policies, priorities, or strategies in organisations ignore the needs of older women. I did not gain any data on this. The use of structured or semi structured interview may have remedied this. Questions could have enquired directly into policies, priorities, and strategies. Further, with improved knowledge of the distinct differences between safeguarding and DVA organisations, I would consider different interview schedules for the two groups but maintain some commonality between them.

The sample range I employed is not representative and it is impossible to generalise the findings from such a small pool of participants. This has given rise to some of my suggested priorities for future research, particularly to explore the experiences of abused older people from minority groups. While the sample range of professionals was reasonably representative in terms of age, length of time in role and location (see appendix 3), 20 out of 21 were White British. A community safety officer in Bowen and Searle (2019) said that due to cultural differences Black African social workers do not always see things as a crime. To test this perception, research that includes practitioners from different cultural backgrounds is required.

My findings fail to offer any real insight into the extent of violence and/or abuse against older people. While this is a valid criticism, I did not aim to expose the extent. If this was however an intended aim, future research could include a quantitative element. Bows (2017c) advocates that a mixed method approach was particularly appropriate for exploring sexual violence against people aged 60 years and over. The success of

her findings provide evidence of this, as they influenced the Office for National Statistics decision to trial the collection of statistics on sexual violence and DV for the over 60s in its Crime Survey for England and Wales (Durham University, 2017). Given the enactment of the Domestic Abuse Act (2021), freedom of information requests could be used to gain data on police recorded DVA, across the UK. An intersectional feminist lens could be employed to examine the interplay of key characteristics, particularly gender, age, and race. It is outside the ambit of this chapter to detail how FOI requests need to be approached and constructed, but worthy to note that they need to be structured in a specific way to gain data and mitigate issues, such as refusals to disclose (Brown, 2009; Fowler et al, 2013; Johnson and Hampson, 2015; Savage and Hyde, 2014; Walby, 2018). Further, while FOI requests do not seem to require the same ethical scrutiny as qualitative methods (Savage and Hyde, 2014; Walby, 2018), when applying for ethical approval I recommend including their use in the application.

Th benefits of a mixed methods approach is that the quantitative element could help indicate the extent of DVA against older women, at a national level, and what characteristics increase risk, while the qualitative aspect could seek to explore the lived experiences of victims and/or those that have observed it. This approach has the potential to promote an understanding of the extent of DVA against elders, and how it is possibly influenced by geographical locations, alongside intersecting social identities and the inequalities associated with them. Notwithstanding this, there are limitations that would require acknowledgement. Bows and Westmarland (2017) concisely and comprehensively do this, by documenting the limitations of using police recorded data to examine the extent of sexual violence against older women. In particular, the recording of racial identity is often limited.

8.6: Final words

Despite feminist research being at the forefront of examining violence and/or abuse in women's lives (Stanko, 1990), the experiences of older women have been somewhat ignored (Bows, 2019a). While there is a small pool of emerging research, the lived experiences of many older victims have been ignored, and there are no studies, in the UK, that have taken an intersectional feminist lens that is informed by social constructionism epistemology. This thesis is the first UK study to employ this

framework and thus builds on previous studies by offering a more nuanced understanding of violence and/or abuse against older women, that is obscured by focusing on age or gender alone.

It sets out the stories of 13 older women, who disclosed various types of violence and/or abuse, and a range of inequalities and factors that shaped their experiences, and help seeking behaviour. It also gives details of the experiences of DVA practitioners and social workers, the challenges they face, and the support they provide. By listening to the voices of victims and professionals, experiences that have been undocumented by previous UK studies is foregrounded. This includes coercive control outside of IPV contexts, abuse by professionals from social services, and details of abuse in care homes. By contextualising findings in an intersectional feminist framework that is informed by social constructionism epistemology, I also add originality to previous USA findings that explored abuse against older women by their adult children (Smith, 2015). Moreover, it brought a nuanced account of abuse by care workers in car homes and in people's homes. I argue that their ability to provide adequate care is impacted by austerity measures and neoliberal ideology. These wider systemic issues and the abuse of power also foster and create an environment for abuse against older people by practitioners from social services. Victims' less powerful status not only places at increased risk, but also prevents them from seeking support. I tease out the individual and systematic factors which perpetuate abusive situations and act against their resolution. While some of these have been acknowledged in previous research, I have additionally shown how these intersect. I demonstrate that the combination of gender, age, ageism, and disability are particularly powerful in causing shame and preventing disclosure.

Stark attention is drawn to the consequences of NDA on victims which helps demonstrate the importance of moving away from understandings of victimisation that only focus on individuals in intimate, or family relationships. Given the negative consequences, arguments can be advanced that some form of free service should be available for NDA survivors which helps them process the emotional effects of their victimisation. Additionally, my research has demonstrated how older female victims can demonstrate empowerment. This helps break down stereotypical notions

associated with inequalities, particularly age and gender, which comprise the ability of older victims to achieve or uphold self-sufficiency or take control of aspects of their lives.

Listening to the experiences of DVA workers and social services when they work with older women victims helps further understand how services recognise and respond to older victims, and the challenges they face. In terms of responses by social services, I argue that their practices are ground in ageist views which, alongside a lack of training, impacts on their ability to effectively support older victims. For both groups of professionals, likewise to previous findings (Carthy and Bowman, 2019), they report confidence issues and a general desire to receive some form of training focused on or including older women.

Of key relevance is the finding that social services lack an awareness of DVA and that due to this, and ageist assumptions, they fail to utilise and share knowledge with specialist support services. Additionally, their lack of DVA knowledge affects their ability to assess the extent control tactics used by DVA perpetrators impact on decision making to engage with services. Further, there is a tendency to assess risk using in house tools, as opposed to DASH, even when enquiries involve DVA. This is concerning because the chances of fatality are increased if risks are not properly assessed (Sharp-Jeffs and Kelly, 2016).

The impact of budget cuts and austerity is well voiced by DVA workers, and I show how this has negatively affected the social care sector and DVA organisations, and the knock-on impacts on older victims. The lack of services and/or their suitably for older survivors are expressed, alongside a hope of remedying this by increasing outreach services and implementing tailored provisions. Yet this is tempered with an awareness that these developments require funding, which is difficult in the current climate.

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Legislation and regulations

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Care Act 2014 (CA)

Crime and Disorder Act 1998 (CDA)

Data Protection Act 2018 (DPA)

Domestic Abuse Act 2021 (DAA)

Domestic Violence, Crime and Victims Act (2004)

General Data Protection Regulations 2018 (GDPR)

Health and Safety at Work Act 1974

Mental Capacity Act 2005 (MCA)

Serious Crime Act 2015 (SCA)

Sexual Offences Act 2003 (SOA)

Social Services and Wellbeing (Wales) Act 2014 (SSWWA)

Case law

'A Local Authority v DL, RL and ML' (2010) England and Wales High Court (family), case 2675.

'NCC v PB and TB' (2014) Court of Protection, case 14**.**

'Local Authority X v MM and KM' (2007) England and Wales High Court (Family), case 2003, (2007) England and Wales High Court (family), case 2689.

Appendix 1: Table of organisations contacted to advertise research and places adverts were placed.

	Organisation	Permissions
1	mumsnet (email) Just victims	Allowed to on www.mumsnet.com/Talk/surveys_students_non_profits_and_start_ups
2	Gransnet (forum) Just victims	Require £30 media fee.
3	Action on Elder (email) enquires@elderabuse.org.uk Just victims	No response – mails sent: 22/07/2019 02/09/2019
4	Age UK National (online contact message request) Just victims	Could not assist – resources/cost. Contacted various AGE UK across North East – either no response or said they could not support request (cost/resources).
5	British Red Cross (email) contactus@redcross.org.uk Victims and professionals	No response – mails sent: 21/07/2019 02/09/2019
6	Denmark Street 460731 t.carey@nhs.net GP surgery Darlington Victims and services	Have taken posters and are putting them up around the surgery Invite to talk/present at upcoming meetings
7	Clifton Court 465646 andrea.francis5@nhs.net GP surgery Darlington Victims and services	No response
8	Orchard Court 465285 rmcmain@nhs.net GP surgery Darlington Victims and services	No response
9	Neasham Road 461128 neashamroad.surgery@nhn.net GP surgery Darlington Victims and services	Have taken posters and are putting them up around the surgery

10	Moorlands 469168 sheena.adams @nhs.net GP surgery Darlington Victims and services	No response
11	Whinfield 481321 louisehoggett@nhs.ne t GP surgery Darlington Victims and services	No response
12	Women's Peer Support Group (Darlington) rsacc.dton@gmail.com Victims and services	No response – mails sent: 22/07/2019 02/09/2019
13	Family Help info@familyhelp.org.uk Victims and services	Will advertise and pass on to other agencies. Invite to give an informal 10 minute presentation on 18th September at Domestic and Sexual Abuse Network (DASAN). Conference in the North Lodge budling Gladstone Street Social Services. Gained 2 survivors, also 2 DA workers
14	Volunteer forum (age UK - Darlington) lynn.walton@ageuknyd.org.uk Victims and services	No response – mails sent: 22/07/2019
15	LGBT Older Support Group - Darlington karen.robinson@ageuknyd.org .uk Victims and services	No response – mails sent: 22/07/2019 02/09/2019
16	Age UK Darlington Simon.davidson@ageuknyd.go v Victims and services	Responded saying they could advertise research but then they failed to follow through on this.

17	Gateshead Older People's Assembly (online contact message request) Victims and services	Have confirmed receipt of email and said they will get back to me (22/07/2019 2nd mail asking again – 02/09/2019 – no response.
18	Golden Age Forum (Ashington) ThomasYERoll@aol.com Victims and services	No response – mails sent: 22/07/2019 02/09/2019
19	Darlington Association on Disability mail@darlingtondisability.org Victims and services	No response – mails sent: 22/07/2019 02/09/2019
20	Darlington Mind contactus@darlingtonmind.com Victims and services	No response – mail sent: 22/07/2019
21	First Stop info@darlingtonfirststop.org.uk Victims and services	No response – mails sent: 22/07/2019 02/09/2019
22	700 Club (online contact message request) Victims and services	No response – mails sent: 22/07/2019
23	Rape and sexual abuse counselling centre (online contact message request) Victims and services	No response
24	Elders Council pauline.rutherford@elderscouncil.org.uk	Advert in October (end of) magazine - E-Bulletin

	Victims and services	
25	Active Voices jmurphy@wea.org.uk Victims and services	Advertising through sharing printed posters with partners or putting adverts up in course venues on the general noticeboards
26	Salvation Army info@salvationarmy.org.uk safeguarding@salvationarmy.org.uk Victims and services	Advertised in centres across the North East
27	U3A (online contact message request) Victims and services	No response
28	Facebook Victims and services	Open forum- advertised through this
29	National Care Association (online contact message request) Victims and services	No response
30	GOLD magazine	Will appear in next magazine. Gained direct referrals from members of GOLD – led to 6 survivors
31	CAB – Darlington	Adverts on CAB general website CAB FB & Twitter – went live 17th September Partner of victim saw advert – told partner about it.
32	Everycare (care provider) **England – London and SE** barnet@everycare.co.uk centralsurrey@everycare.co.uk info@everycareeastsurrey.com eastbourne@everycare.co.uk	No response from any of them

	hertfordshire@everycare.co.uk hastings@everycare.co.uk hillingdon@everycare.co.uk hello@everycareiow.co.uk medway@everycare.co.uk midsussex@everycare.co.uk reading@everycare.co.uk romford@everycare.co.uk westkent@everycare.co.uk England – the north, central & Midlands miltonkeynes@everycare.co.uk oxford@everycare.co.uk everycarerugby@btinternet.com info@everycarewirral.co.uk England – South West hampshire@everycare.co.uk info@everycare-wessex.co.uk Wales bridgend@everycare.co.uk cardiff@everycare.co.uk deeside@everycare.co.uk newport@everycare.co.uk swansea@everycare.co.uk Scotland edinburgh@everycare.co.uk	
33.1	CAB Newton Ayliffe – 0300 323 1000	No response
33.2	Stockton - support@stockton-cab.co.uk	No response

33.3	Richmond – advice@northyorkslca.org.uk	No response
33.4	Middlesbourough – online contact	No response
33.5	Hartlepool - enquiries@hartlepool.cabnet.org.uk	No response
33.6	Redcar & Cleveland admin@redcarcab.cabnet.org.uk	No response
33.7	Craven & Harrogate – online contact	No response
33.8	Medway - info@medwayadvice.org.uk	No response
33.9	Sittingbourne -& Faversham admin@citizensadviceswale.uk	No response
33.10	Maidstone – online contact	No response
33.11	Cranbook – advicecranbrook@catwd.org.uk	No response
33.12	swanley@nwkent.cab.org.uk	No response
33.13	info@sevenoaks.cab.org.uk	No response
33.14	Erith - Bexley – online form	No response
33.15	Tunbride Wells - advice@catwd.org.uk	No response
33.16	Canterbury - canterburycab@cabnet.org.uk	No response

33.17	Havering – Essex – online contact form	No response
33.18	Edenbridhe @ Westerham edenbridge@cabnet.org.uk	No response
33.19	Towcester towcester@cencab.org.uk	Agreed to advertise
33.20	Daentry - enquiries@daventry.cabnet.org.uk	No response
33.21	Oxfordshire (Witney) info@citizensadvicewestoxon.org.uk	No response
33.22	greensquareha@citizensadvicewestoxon.org.uk	No response
33.23	advice@oxfordshiresas.org.uk	No response
33.24	South Warkshire – online form	No response
33.25	thame@osavcab.org.uk	No response
33.26	abingdon@osavcab.org.uk	No response
33.27	admin@aylesburycab.org.uk	No response
33.28	Rugby - adviser@brancab.org.uk	No response
33.29	Linslade - advice@leightonlinsladecab.org.uk	No response
33.30	citycab@newcastlecab.org.uk	No response
33.31	advice@citizensadvicegateshead.org.uk	No response

33.32	South Tyneside - admin@southtynecab.net	No response
33.33	West Sussex – online form	No response
33.34	Cambridge - caba@cambridgecab.org.uk	No response
33.35	adviser@newmarketcab.cabnet.org.uk	No response
33.36	Essex - bureau@uttlesfordcab.cabnet.org.uk	No response
33.37	West Sussex – cs.bureau@westsussexcab.org.uk	Unbale to promote research as conflicts with some local research.
34	Independent Domestic Abuse Services – Yorkshire Info @ IDAS <info@idas.org.uk	Gained 3 DV workers through this. Victims???? TBC
35	Brian Davies – Care UK – brian.davies@careuk.com	No response
36	PHD wellbeing facilitators Wellbeing.facilitators@nhs.net 01325 952455	No response
37	Social Care Institute for Excellence Media enquiries Steve Palmer, Communications Manager Telephone: 020 7766 7419 Mobile: 07739 458 192 Email: media@scie.org.uk	No response
38	Tyneside Women's health Online message form	Advised to contact EVA

39	Research gate	Online research forum – details of project given and asked for help to advertise awareness
40	Harbour info@myharbour.org.uk	02/09/2019 Arranged visit to refuge. 4 DA workers and 2 victims
41	Family action info@family-action.org.uk; media-pr@family-action.org.uk	17/09/2019 People they support do not fit demographic
42	Healthy Living Centre, Dartford info@hlcdartford.org.uk	Said they could not support due to resources.
43	Darlington adult safeguarding managers: suzanne.joyner@darlington.gov.uk	No response
44	Dorset adult safeguarding manage: sally.march@dorset.gov.uk:	1 social worker
45	Medway adult safeguarding manager:	1 social worker
46	EVA	Could not support – no reason given
47	Silver	Could not support – lack of time and resources
48	Sorptimist	No response
49	Choice (DA service in West Kent and Medway)	Asked staff – 1 said yes. Possible victims.
50	Redcar and Cleveland Social Services Manager: adult safeguarding manager: sean.wearn@redcar-cleveland.gov.uk	Details passed to various team mangers – gained 3 social workers via this.
51	Harlepool adult social services: ispa@harlepool.gov.uk	No response
52	Middlesborough adult social services: adultaccessteam@middlesborough.gov.uk	No response
53	Wearside Women in need	1 DA worker

54	Nicholas.Edgar@cleveland.pnn.polic	Passed advertising emails to colleagues
55	Newcastle Adult Social Services: jody.robinson@newcastle.gov.uk	Details passed to various team mangers.
56	Clarion Domestic Abuse Services: centrakent@clarionhg.com	Details passed to various staff.
57	Kent Adult Social Services: karen.heard@kent.ov.uk	Details passed to various team mangers.
58	One Stop shop – Maidstone (Domestic abuse service) info@choicesdaservice.org.uk	Could not support due to resources.
59	Helpline for EA: enquiries@elderabuse.org.uk	No response.

Appendix 2: Demographic information of survivors (self-defined).

Pseudonym	Age	Disability	Ethnicity	Social class	Religion
Angus	70	Yes – mobility	White/British	Working	CoE
Ellen	67	Yes – mobility and mental health difficulties Learning problems	White/British	Middle	None
May	67	No	White/British	Working	Spiritual
Scarlett	66	Yes – mobility	White/British	Working	CoE
Ricky	82	No	White/British	Affluent	CoE
Linda	67	Yes – hard of hearing	White/British	Middle	None
Caroline	92	Yes – physical support needs, required support in most aspects of care, including washing*, dressing etc; and could not cook meals for herself.*	White/British	Working	None
Joan	69	Yes – mental health & physical	White/British	Middle	Spiritual
Korine	73	Yes – mobility issues	White/British	Working	None
Victoria	72	No – but past cancer	White/British	Working	None
Sharron	66	Yes - severe mobility issues and metal health difficulties	White/British	Working	CoE

Joanne	64	Yes -mobility and mental health difficulties	White/British		None
Tegan	66	Yes - mobility and mental health difficulties	White/British	Working	TBC

Appendix 3: Demographic information of professionals

Pseudonym	Role/team (self-defined)	Length of experience	Number or % of older women victims worked with
		DV/DA/IPV professionals	
Abbie	DA support worker	6 years	2 in the last year
Sylvia	IDVA – support worker	14 years	3 or 4 in last year
Rachel	IDVA - support worker	16 years	10 in the last year
Mia	Local manager of DA support/refuges	1 year but previous similar DA support role (8 years)	1 in the last year, but *“more in previous role”*
Pink	DA support worker	2 years, 6 months	About 5 over career
Millie	Refuge support worker	9 months	1 over career
Bella	Support worker – outreach DA	8 years	4 over career
Jennyren	Senior support worker (refuge)	4 years	2 in the last year
Mandy	Assistant chief officer – previously manager of refuge	34 years	1 in 20 are older survivors

Vivian	DA support worker	20 years	3 in the last year
Jenny	DV and DA practitioner	2 years	10 in the last year
	SOCIAL SERVICES		
Jean	Community wellbeing	1 year - previously worked in adult safeguarding (3 years)	15 out of 30
Isobel	Community wellbeing	3 years, but previously worked in older persons team within social services (7 years)	2 or 3 a month
Ellie	Community wellbeing	1 year	26 out of 30
Harmony	Adult safeguarding	7 years	On average: 80 %
Maria	Head of adult safeguarding	8 years in adult social work – 6 years in management	Implied as working with many over career but none currently (manager)
Jessica	Adult/ older mental health	1 year, 7 months (newly qualified)	Limited so far
Betty	Independence team	9 months (newly qualified)	10 over career
Angela	Adult access manager	7 years in adult social	Half the reports that go to the team are

		work – 1 year in management	safeguarding for older adults
Beryl	Safeguarding adult's manager	3 years in current role but previously worked in adult safeguarding team (5 years)	Implied as working with many over career but none currently (manager)
Anna	Ongoing assessment and intervention	10 years	Frequently

Appendix 4: Interview schedule with women survivors

Draft interview schedule

Before starting the interview, I will go through the following:

Hello, I am Emma and first I would like to thank you for agreeing to participate in this research and talk to me today. You have already been given the information sheet and therefore hopefully know why this study is being undertaken. But just to confirm, I am seeking to talk to you about your experiences of abuse and also to discover if you have had any experiences in your past. I am also interested in hearing your experiences or views on support services or networks.

Some of the matters you discuss today may cause you emotional discomfort and I would like to reassure you that you are under no obligation to discuss issues unless you would like to, you can give as much or little information as you feel comfortable with. At any point we can pause the interview, or it can be completely stopped. You do not have to provide any reason, you just need to let me know. You are also free to withdraw your contribution after the interview. I have also provided you with a list of national support services you can contact if you would like support from a specialist service. If you withdraw from the study then any present or possible future contact with services will not be impacted.

The interview is expected to last from one hour to an hour and a half, but I have plenty of time so please do not feel rushed, talk as much or little as you want. There are 11 initial questions so we can get to know each other, and help you feel as at ease as possible, 5 main questions and closing question(s) about positive experiences in your life. The main questions are just a framework and I may therefore provide prompts or additional questions depending on your answers. If you do not wish to answer a question then this is fine, you can answer as much or little as you feel comfortable with. You are also free to discuss other issues that you deem relevant if you wish.

Consent – before we start this interview I have a consent form for you to read, and if you agree, then sign. You can either read it, or I can read it to you, whichever is more comfortable for you. If you wish to use a different name, that is also fine.

Do you have any questions before we begin?

About you and building rapport section

In order to learn a bit about you, I would be grateful if you could answer the following questions about yourself.

1) How would you like me to address you? – by name etc?
2) How did you hear about this research?
3) Have you always lived locally?
4) How would you describe your social class?
5) What would you class as your religion, if applicable?
6) If you work, what is your current occupation? If you no longer work, have you worked in the past? Types of roles?
7) How would you describe your current relationship status?
8) How would you describe your race/ethnicity?
9) Would you class yourself as having any form of disability, this can include learning problems, and physical or mental disability.
10) How old are you? Or what age bracket?
11) When discussing your experiences of abuse, would you prefer the use of the term victim or survivor? How do you feel about the term elder abuse?

Now I know a little bit about you, we are going to move on to the main part of the interview. Do you feel ready to proceed? Just to remind you that if you need to take a break or stop the interview, please just let me know.

Experiences

Q1) Can you tell me about your experiences of abuse?

Prompts if needed:

When did it start?

How did it start?

Who is/was the perpetrator?

What barriers did you face, or do you face to stopping it? What influenced these views/barriers?

Would you say you felt/knew you were being abused?

Impacts

Q2) Can you tell me about the impacts your experiences of abuse had/have upon you?

Prompts if needed:

Has it affected the way you live your life? Did it cause you to change the things you do, the activities you take part in etc?

What coping mechanisms did/do you use?

Has it impacted on the way you act/relate with others? Do others treat you differently?

Q2B) Thinking about the impacts you have just described do you think these would have been the same or different if it had happened earlier in your life?

Experiences of seek helping, or views on this

Q3) What are your views or experiences on seeking help?

Prompts if needed:

Did you tell friends?

Did you tell family?

Did you contact support groups? Online support? Counselling?

Did you ever call the police?

Do you feel others in society (police, doctors etc) know enough about elder abuse? What might they need to know to help elders seek support?

For any of the above – if needed the following prompts/questions will be asked:

What did you tell them?

What was their reaction?

How did you feel?

Was seeking support helpful or not?

What was the most helpful source of support and why?

What was the least helpful and why?

If the victim has accessed formal support, the following prompts will be given, if required

How long have you been seeing this person (support worker, counsellor etc). Since it started, last happened etc?

Did it take some time to seek this support? How long did you have to wait after seeking support?

How did you find out about them/know where to go for support?

Q3B)

As this research is specifically interested in women over 60, do you mind if I ask you if you think your age made it more or less difficult for you to find and gain support? If yes, what barriers do you think you faced?

Do you think you were treated any differently because of your age? Do you think your experiences of the process would have been different if you were younger?

Continuum of abuse (only to be asked if participant has not spoken about previous abuse prior) – use life-course aid to map abuse.

Q4) Did you experience any violence and abuse, including neglect before you were 60?

If yes, if needed, use prompts for q1 above.

Q4B) Thinking about the impacts you described earlier, do you think these were different to the impacts you have experienced later in your life, and if so, how?

Q5) Please describe anything else you would like to discuss.

Closing questions to promote emotional recovery

Can you tell me about a positive experience in your life?

Note: If participant has disclosed positive information in the opening questions, these will be used to frame closing questions with the aim of promoting emotional recovery from the interview.

Appendix 5: Interview schedule with professionals

Draft interview schedule

Before starting the interview, I will go through the following:

Hello, I am Emma and first I would like to thank you for agreeing to participate in this research and talk to me today. You have already been given the information sheet and therefore hopefully know why this study is being undertaken. But just to confirm, I am seeking to talk to you about your experiences of working with elder abuse victims, or if you have not worked with them, your views on what this might be like. I am also interested to gain insight into types of training you have had and what if any changes have occurred since the Care Act 2014 came into force.

Some of the matters you discuss today may cause you emotional discomfort and I would like to reassure you that you are under no obligation to discuss issues unless you would like to, you can give as much or little information as you feel comfortable with. At any point we can pause the interview, or it can be completely stopped. You do not have to provide any reason, you just need to let me know. You are also free to withdraw your contribution after the interview.

The interview is expected to last from 45 minutes to an hour, but I have plenty of time so please do not feel rushed, talk as much or little as you want.

There are 3 general questions about you, 4 main questions and a closing question about a positive experience in your life. The main questions are just a framework and I may therefore provide prompts or additional questions depending on your answers. If you do not wish to answer a question then this is fine, you can answer as much or little as you feel comfortable with.

Consent – before we start this interview I have a consent form for you to read and if you agree, then sign. You can either read it, or I can read it to you, whichever is more comfortable for you.

Do you have any questions before we begin?

About you

To learn a bit about you, I would be grateful if you could answer the following questions about yourself.

1) What is your role within your current occupation?
2) How long have you worked in this role?
3) If you have worked in other roles, was it similar/different from the role you are in now?

Now I know a little about you, we are going to move on to the main part of the interview. Do you feel ready to proceed? And just to remind you, that if you need to take a break or stop the interview, please just let me know.

Experiences/views

Q1) What experiences have you had working with victims over the age of 60?

Prompts if needed

What types of abuse have been disclosed to you? Types of EA aware of?

Who are the victims? Perpetrators?

What types of tools have you used/do you think you would use to measure risk?

What types of interventions have you put into place/ think you would put into place?

How would you approach putting interventions into place?

What level do you involve, or think you would involve older victims in the decision-making process?

Challenges faced?

Training

Q2) Can you tell me about the types of relevant training you have had?

Prompts if needed

What did it cover? Was it optional/mandatory?

Was it specifically tailored to older victims/do you think it should be?

How often is training given?

To what extent are you guided by definitions (EA, DV etc)?

What challenges do you feel you have faced/or might face in recognising/responding to EA?

Q3) Can you tell me what if any changes you have made/seen since the Care Act 2014 came into force?

Experiences of working with/referring to other organisations? Changed since CA?

Changes to how work with victims?

Changes to interventions put into place?

How often are criminal proceedings brought? Less/more than younger victims and why?

If no knowledge on CA, or limited

Ask if they feel it would be beneficial for workers/volunteers to have training/knowledge around the CA? (if needed explain main provisions)

What guidelines/legislation and definitions do you work with?

Q4) Please describe anything else you wish to discuss.

Closing question

Can you tell me about a positive experience in your life?

Appendix 6: Consent form

CONSENT FOR TAKING PART IN A STUDY THAT MAY CAUSE PSYCHOLOGICAL DISTRESS

Project title: Abuse amongst older women: their voices; prevalence and services experiences.

Principal investigator/ researcher: Emma Finnegan

Please read the following statements and tick the box next to it to signify your consent to each and provide your name, signature and date below to further clarify consent. To prevent identification, please be reminded that this consent sheet is kept separately from your interview transcripts. However, if you wish to use a different name to further protect your safety, please do.

I have read and understood the participant information sheet.	
I have read and understood the purpose of the study.	
I have been given the opportunity to ask questions about the study and these have been answered to my satisfaction.	
I have been informed that I can gain a written report of the analysis and can make comments. I am aware of how to gain this.	
I understand that I can withdraw at any time if I change my mind without having to provide a reason and without prejudice.	
I agree to take part in this study.	
I am willing for my comments to be recorded.	
I am aware that my name and details will be kept confidential and will not appear in any printed documents	
I understand that by taking part in this study I may experience psychological distress that may become apparent during and/or after the study has finished. I accept the risk of experiencing psychological distress as part of this research.	
I consent to the retention of data I provide under the condition that any subsequent use also be restricted to research projects that have gained ethical approval from Northumbria University.	

I consent to the processing of the special category data that was specified in the participant information sheet.	

Name……………………………….

Signature ……………………………….

Date…………………………………….

Please also read the below statement of confirmation and sign to signify your understanding and consent.

Statement of confirmation

The information I provide, including the specified special category data will be held and processed for the purposes of the research project: Abuse amongst older women: lived experiences; prevalence, nature and how services recognise and respond to it. I agree to the University of Northumbria at Newcastle recording and processing this information about me. I understand that this information will be used for the purposes set out in the information sheet supplied to me, and my consent is conditional upon the University complying with its duties and obligations under the Data Protection Act 2018 and the General Data Protection Regulations. NAME…………………………………………….. SIGNATURE……………………………………..DATE…………………

If you are dissatisfied with the University's processing of personal data, you have the right to complain to the Information Commissioners Office. To do this, you can visit

https://ico.org.uk/make-a-complaint/

and start a live chat

or call their helpline on: 0303 123 1113.

SW1P 3HZ

directors of
adass
adult social services

18 Smith Square
London

22 June 2020

Our Ref: RG20-02

Dear Emma,

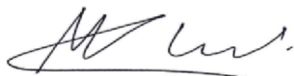
Research Proposal – Abuse among older women: their voices, prevalence, and services experiences

I am writing on behalf of the Association of Directors of Adult Social Services (ADASS). I am pleased to inform you that ADASS Executive Council agreed to endorse your research project during their meeting on 11th June 2020. When contacting local authorities please include this letter as proof of endorsement.

In the interests of ensuring that adult social services departments receive the maximum benefit from co-operating in research projects such as your own, ADASS places great importance on disseminating findings and conclusions. It encourages researchers to find ways, including (but not exclusively) formal publication of a report, of feeding back the results of their research to participating departments. We would welcome a short summary of the findings of this project, once you have completed it, in a form suitable for distribution to adult social services departments. We would also appreciate knowing your expected publishing date.

Please do not hesitate to contact me if you have any further questions.

Yours sincerely



Michael Chard ADASS Senior Officer

The Association of Directors of Adult Social Services
ADASS, 18 Smith Square, London SW1P 3HZ
Tel: 020 7072 7433 Email: team@adass.org.uk Website: www.adass.org.uk

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