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## Review

# The impact of domestic abuse for older women: a review of the literature

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### What is known about this topic

- Domestic abuse is a significant health issue globally.
- Domestic abuse exerts a significant impact on the health status of all women who have experienced abuse.
- There is currently little available data regarding older women and domestic abuse.

### What this paper adds

- Healthcare professionals often do not acknowledge domestic violence as being a potential issue for older women.
- Older women who have experienced domestic abuse have particular health and support needs.
- The services that currently exist may not be appropriate to meet the needs of this group of women.

## Abstract

The consequences of domestic abuse are far reaching, impacting significantly on long-term health and emotional wellbeing of those affected. However, while the literature offers an insight into the scope and nature of domestic abuse among the younger population in the UK, there is currently little available data regarding older women and domestic violence. This is increasingly being recognised as a significant deficit in awareness and understanding within society as a whole and more particularly for those responsible for support and care provision. While research in this area may be scarce the work that has been undertaken to date would suggest that domestic abuse is both a significant and an under-recognised phenomenon, which has a wide-ranging impact on the lives and health of older women. It also suggests that older women's experiences of domestic abuse are markedly different from those in younger age groups and that these differences have not been adequately acknowledged or accounted for. Given that the UK has an ageing population and that emerging national policy initiatives are beginning to recognise domestic abuse as an issue for older women, it is fundamental that health and social care professionals are able to both identify domestic abuse and understand the particular experiences and needs of older women affected by domestic abuse. The aim of this literature review is threefold: (i) to provide a comprehensive summary of the impact of domestic abuse for older women particularly within the context of health, (ii) to explore the particular barriers to recognition and reporting abuse and (iii) to highlight the particular gaps in our knowledge and understanding from a policy and care provision perspective. A systematic approach to a review of the literature was used to identify key literature and available evidence relating to domestic abuse among older women.

**Keywords:** domestic violence, health policy, older people, women

## Introduction and background to the review

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

In the UK, it has been estimated that approximately 23% of women and 15% of men aged 16–59 years have

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been assaulted by a current or former partner, while 26% of women and 17% of men have experienced physical or non-physical domestic abuse from a partner (Department of Health 2000a,b). However, while the literature offers an insight into the scope and nature of domestic abuse among the younger population in the UK, there is currently little available data regarding older women and domestic abuse. This is increasingly being recognised as a significant deficit in awareness and understanding within society as a whole and more particularly for those responsible for support and care provision (Blood 2004).

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

Additionally, there are a number of other factors that contribute to this deficit in current knowledge, for example, barriers to disclosure (Acierno *et al.* 2001) and the failure of health and social care professionals to recognise domestic abuse as occurring in this age group (Women's Aid, 2007). This again signifies the stereotypical images that may exist supporting the view that domestic abuse mainly affects younger women. Moreover, it has been highlighted that the way in which domestic abuse has been poorly defined among older women or subsumed under the generic term of elder abuse homogenises older people rather than recognising individual differences, including gender (Hightower 2002).

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

Furthermore, while it is argued that domestic abuse should be a matter of public concern, the current focus on support for carers within the context of abuse among older people perpetuates the issue as a private matter rather than a public one (Sargent 1995). For example, a number of authors (Desmarais & Reeves 2007, Wolf 1996) have argued that historically approaches towards abuse of older people have been based on an elder abuse model that does not acknowledge the complexity of the relationship between the abuser and the abused.

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

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

Given that the UK has an ageing population and that emerging national policy initiatives are beginning to recognise domestic abuse as an issue for older women (Blood 2004, Greenan 2004), it is fundamental that health and social care professionals are able to both identify domestic abuse and understand the particular experiences and needs of older women affected by domestic abuse. Ultimately, this has real implications for the development of collaborative services that are responsive to the needs of older women.

## The review

### Aim

Given the paucity of available evidence from the specific perspective of older women, the aim of this literature review is threefold: (i) to provide a comprehensive summary of the impact of domestic abuse for older women particularly within the context of health, (ii) to explore the particular barriers to recognition and reporting abuse and (iii) to highlight the particular gaps in our knowledge and understanding from a policy and care provision perspective. This literature review subsequently forms the basis of a study exploring older women's experiences of domestic abuse and the impact on the lives and health of these women. The particular focus on health arises from observations from a number of key commentators that this remains a deficit in knowledge and understanding of older women's experiences to date (Blood 2004, Women's


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Aid, 2007). For the purposes of this review, older women were defined as those aged 55 years or over.

## Search methods

A systematic approach to a review of the literature (Aveyard 2007) was used to identify key literature and available evidence relating to domestic abuse among older women. A search was carried out of the databases for CINAHL, Social Science Citation Index (SSCI), Medline, Psychinfo, British Nursing Index (BNI), between 1980 and May 2010. The rationale for the search parameters in terms of years was based on issues relating to definition and invisibility of this phenomenon, for example, elder abuse and domestic violence (abuse) has only relatively recently been evident within public discourse. Key words and search terms used included: domestic abuse [violence], older women [aging/ageing], health-care [experiences], women's health. In addition, specific terms were also used for emerging sub-themes, for example ethnicity, support and screening. Due to the breadth of reporting, papers were accessed and reviewed from a range of both UK and international journals across a range of disciplines.

In addition, a search was also carried out of the 'grey literature', for example national and international policy documentation and commissioned reports. Key national government and charitable organisation websites were accessed for the purposes of commentary and reports. References were also manually 'hand searched' from key journals and reference lists and from relevant websites. Papers were only included if they were peer reviewed, published in English on or after 1980 and primarily related to the issue of domestic abuse. In order to meet the aims of the review, papers had to focus on domestic abuse within the particular context of older women and health. For the purposes of the review, the quality of the papers was appraised independently by two researchers using a structured approach, which included addressing questions relating to design, sample, data collection and analysis, background of authors, quality of journal, review process and clarity of writing (Aveyard 2007). This approach to the quality assessment process has been utilised elsewhere (Robinson & Spilsbury 2008).

While the focus of the review was domestic abuse and older women, the search process highlighted a number of methodological challenges. A particular example was the lack of conceptual clarity regarding definitions of domestic abuse among older women as highlighted in the earlier background section and subsequently found within the literature. As suggested earlier, while there is clearly a distinction between domestic abuse and elder abuse, in many instances it was evident that this difference had not been clearly articulated by the authors. As such, while 113 papers were initially identified, only 42 papers or reports in total met the inclusion criteria as highlighted above in terms of relevance, and were therefore included in this review. Of these, 32 papers explicitly considered health issues of women of all ages, including older women and of these 19 were empirical studies or analysis of existing surveys or epidemiological data, the remainder comprising a combination of reports, commentary and review papers. A synthesis table of the key papers identified was developed in order to summarise each paper individually, to gain a clear understanding of the content of the papers and to identify emerging themes (Table 1). These themes are detailed in the following discussion.

## Impact of domestic abuse on the health of older women

The impact of physical abuse over a period of time may significantly impact on both the short and long-term health status of older women, including permanent physical damage and disability (Women's Aid, 2007). In a review of the literature carried out in Australia by Morgan Disney & Associates (2000), it was argued that the impact of physical abuse for older women can be far ranging, resulting in a high incidence of trauma-related injuries and physical conditions, for example gastro-intestinal disorders, genitor-urinary and musculo-skeletal disorders. In a telephone survey conducted with 842 women aged 60 years and over living in the community, Fisher & Regan (2006) identified that older women who had experienced abuse (including physical, psychological and sexual abuse) are more likely to experience an increased incidence of a range of physical and mental health problems than those who have not experienced abuse. However, they also highlight that older women who have experienced abuse may not report lower general health, but are more likely to experience a detrimental impact in terms of specific health conditions, for example hypertension or chronic joint pain. Similarly, in a study undertaken by Mouton *et al.* (2004), which analysed the survey responses from a health study questionnaire with 93 000 women aged 50–79 years, older women's experience of domestic abuse corresponded to those in younger age groups and they suggest that this has real implications for the health of older women, though they do not elaborate further. However, while these studies arguably provide an insight into the potential prevalence of domestic abuse among older women, they do not offer an account of the specific experiences or impact of abuse.

Ultimately, the consequence of prolonged exposure to physical assault is significant long-term health problems and premature death (Women's Aid, 2007, Coker

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**Table 1** Synthesis of the key papers identified

| | Author/date | Type of study/paper | Aim and overview | General comments and strengths and limitations of the paper |
|---|---|---|---|---|
| 1 | Acierno *et al.* (2001) | Telephone interview study (interviews) with younger women (18–34 years) and older women (55–89 years) | Comparison study of recently occurring assaults and those of distant past assaults. Participants recruited via a National Women's study in the US. | Considers societal influences on the reporting of assault and sexual violence. Does not explicitly address IPV or DV. |
| 2 | Beaulaurier *et al.* (2007) | Qualitative study (focus groups $n = 21$) with 134 women (45–85 years) | Study exploring barriers to seeking help for older women who have experienced DV. The study was conducted in the US. | Authors recognise limitations in terms of geography of study sample and lack of representation across different cultural communities. However, the study provides a valuable and candid insight into the particular experiences of older women. |
| 3 | Bergman *et al.* (1992) | Qualitative study and treatment intervention programme with women ($n = 117$) of whom 58 agreed to enter the intervention programme. | To study the use of health services by women who experience domestic abuse and to evaluate the success of an intervention programme of the 117 women who were identified through A&E admissions over a 7-month period. The study was conducted in Sweden. | Recognised that this is a dated study. However, limitations also exist in terms of the representativeness of the sample as women identified only through those who reported injuries at an emergency department. There is no inclusion of information regarding the intervention (referred to as a 'treatment programme' and therefore unclear if for the women or the perpetrator). The issues of women attending a programme are also unclear. |
| 4 | Blood (2004) | Provision review | To examine the services that are currently available for older women and the barriers to accessing services and support. UK based. | Provides a clear insight into the particular situation of older women in relation to service provision. Explicitly addresses the needs of older women as opposed to all age groups and highlights clear guidance for future developments in this field. Does not develop the theme of health in depth. |
| 5 | Brandl & Horan (2002) | Discussion paper | To identify definitions and responses to elder abuse. US based | Discussion paper focused towards US statistics in terms of quantifying the problem of elder abuse. Elder abuse and DV are not separated for the purposes of the paper and the terms are used interchangeably. Advocates screening as a requisite for DV and elder abuse – does not consider the opposing literature in this field. |
| 6 | Brandl *et al.* (2003) | Evaluation of survey data identifying older women's DV support groups. | To provide an overview of the support networks and groups for older women within a defined area. US based. | The paper provides an overview of the nature of support groups for older women within a defined area of the US. The paper highlights the perceived benefits of groups through inclusion of data from the studies identified. The paper also includes demographic data from the studies identified. Provides a number of recommendations in terms of developing similar initiatives. There is limited information regarding study sample. |
| 7 | Burman *et al.* (2004) | Action research conducted over 11 months with 26 service providers | To explore general policy questions surrounding DV service delivery and design around gender, class and racialization. UK-based study. | Does not separate out the particular issues for older women. However, offers an insight into the issues surrounding professional perceptions with regard to cultural issues – transferability to issues of gender and later life. |



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**Table 1** (Continued)

| | Author/date | Type of study/paper | Aim and overview | General comments and strengths and limitations of the paper |
|---|---|---|---|---|
| 8 | Coker *et al.* (2002) | Analysis of epidemiological data generated through a national violence against women survey (*n* = 16 000) and random telephone survey. | A population-based study to assess the association between abuse and long-term health. US based. | Highlights some of the potential issues and links between self-reported health status and experience of abuse. Although the title refers to women, the data also included men and this was not clear in the introduction. The survey excluded data from individuals aged 65 years and over and a rationale was not given. Limitations regarding data analysis refer to bias and the inability to confirm particular anomalies within the data, for example to confirm a particular diagnosis due to the size and anonymous nature of the study. Data also missing and therefore results may be skewed with regard to certain variables. |
| 9 | Cole (2000) | Commentary | Discussion surrounding the screening for reduction of DV. US focused. | Provides medical practitioner perspectives towards screening for abuse. No empirical data and largely anecdotal. |
| 10 | Desmarais & Reeves (2007) | Review paper | To consider the state of knowledge regarding IPV and older adults and the implications of blurred distinctions between elder abuse and IPV. Canadian based. | Provides a clear overview of the key arguments with regard to the distinction between elder abuse and IPV. No empirical data but draws on previous work in defining the issues that arose in terms of interventions and support and also highlights the limitations of both bodies of literature in this field. |
| 11 | Feder *et al.* (2009) | Review and synthesis of existing research (*n* = 14 data bases) | To identify appraise and synthesise research that is relevant to selected UK screening committee criteria for a screening programme in relation to IPV and to explore whether current evidence fulfils the criteria for implementation of screening in healthcare settings. | Provides a comprehensive summary of the available data regarding IPV. Reports findings in terms of pre-defined questions relating to efficacy of screening programmes. Report concludes that currently insufficient evidence and highlights areas for further exploration. |
| 12 | Fisher & Regan (2006) | Quantitative study: cross-sectional telephone survey conducted with women aged 60 years and over (*n* = 842) | To assess the experience and range of abuse and the impact of different types of abuse on the health status of older women. US based. | Provides an insight into the particular situation of older women, existing gaps in service provision and potential issues for healthcare providers. The limitations as highlighted by the authors relate largely to the nature of the study and the inability to pursue areas of ambiguity. There is also a paucity of depth in terms of experiences of older women beyond objective health reports. |
| 13 | Flueckinger (2008) | Literature review | Literature review of two published (Scotland) studies that have explicitly addressed older women within the context of DV. Published in Scotland. | Provides an overview of the key findings from two studies undertaken in Scotland – highlights key points and identifies a number of themes and policy implications. Does not explore the background to the studies in any depth. |
| 14 | Greenan (2004) | Literature review | Literature review published by 'Safer Scotland'. | Provides an overview of the literature with regard to violence against women – does not explicitly consider older women but does highlight the paucity of available evidence in this particular area. |

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**Table 1** (Continued)

| | Author/date | Type of study/paper | Aim and overview | General comments and strengths and limitations of the paper |
|---|---|---|---|---|
| 15 | Haggblom & Moller (2006) | Qualitative study (interviews utilising grounded theory methodology) with female expert nurses ($n$ = 10) | To explore expert nurses' experiences of the phenomenon of violence against women and their role as healthcare providers. Finnish study. | The study illuminates nurses' perceptions of identifying DV and their role in care provision. Small-scale study and there is little detail regarding how nurses were identified and their place of work in relation to contact with DV. Nurses also suggested that they failed to identify women who may have experienced DV but this was not developed or explored in the interviews or by the authors. |
| 16 | Harwell *et al.* (1998) | Quantitative intervention study with healthcare workers ($n$ = 108) | To assess the efficacy of a training intervention on 'comfort' of professionals' knowledge and identification of DV. US-based study. | Considered the merits of a particular training approach and highlighted the residual decline of training approaches which is well documented. Small sample in the re-test group made evaluation questionable. The study did not address the particular situation of older women and the design of the study did not allow for researchers to discern particular variables, for example level of screening with regard to increased knowledge. |
| 17 | Hightower (2002) | Discussion paper | To generate discussion surrounding the interrelationships between power, gender, age, control and violence. | Provides a clear perspective of the distinctions and overlaps in terminology between elder abuse and DV. Utilises a global perspective to the discussion. |
| 18 | Mears (2002) | Action research study and the 'collection' of older women's stories ($n$ = 250) through seminars and interviews over a 2-year period. | Provide an opportunity for older women to speak of their experiences in order to highlight their experiences and to develop resources to support and inform older women. Australian study. | Comprehensively addressed the particular situation of older women and aims of the study and methods clearly stated. Does not explicitly address issues and future direction in terms of health-care or service development. |
| 19 | Miller & Jaye (2007) | Focus groups held with general practitioners ($n$ = 18) | To examine GP perceptions of their role in the identification and management of DV, barriers to reporting and perceived prevalence. New Zealand-based study. | GPs felt in a good position to identify DV although estimates of prevalence were lower than community surveys. Barriers were identified in terms of key themes and education was perceived as a vehicle to improve responses. Limitations in terms of the participants (female and European) not representative of GPs across NZ. |
| 20 | Mouton *et al.* (2004) | Study to examine the prevalence of DV among postmenopausal women ($n$ = 93205) recruited from a national epidemiological database. | To explore the prevalence and predictors of physical and verbal abuse among the study population. US based. | Main findings report that older women are exposed to abuse at the same rate as younger women and that this poses a serious threat to their health. Limitations of the study are based on the nature of data collection through survey which relies on self-report. The exclusion criteria for the general survey also mean that only 'healthy' women were recruited in the first instance. |



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**Table 1** (Continued)

| | Author/date | Type of study/paper | Aim and overview | General comments and strengths and limitations of the paper |
|---|---|---|---|---|
| 21 | Moore *et al.* (1998) | A descriptive study of responses to a questionnaire administered to a convenience sample of nurses through post (*n* = 275) | To compare education, attitudes and practices related to DV among perinatal nurses across 3 different care sites. US-based study. | The authors found some differences between the different sites in terms of identification – however, these were not statistically significant. However, significant differences were found in terms of education about DV and impact in terms of attitudes and behaviours. Limitations due to the nature of the study – it was not possible to explore the rationale for not exploring or barriers to reporting in depth. Responses may not represent actual practice. |
| 22 | Morgan Disney and Associates (2000) | Qualitative study involving interviews with older people (*n* = 162) who had experienced DV. | To record the incidence and lived experience of older people experiencing DV. Australian-based study. | The study included both men (*n* = 22) and women (*n* = 140) aged 55 years and over. The study is entitled Two Worlds and highlights the way in which older people who have experienced DV are 'trapped' between two worlds – a world where DV was not acknowledged and the contemporary world. Includes perspectives of both men and women. |
| 23 | Phillips (2000) | Literature review | To discuss the abuse of older women within two contexts: IPV and abuse of ageing care givers. | Discussion of the literature within the context of own research. Highlights a number of potential implications for practice. Utilisation of own research does not provide any details of the study itself and as such a number of gaps in terms of quality assessment. |
| 24 | Robinson & Spilsbury (2008) | Systematic review | To establish the experiences and perceptions of adult victims of DV when accessing healthcare services. | Systematic review with clear quality indicators and search strategy. No specific acknowledgement of older women. Self-identified limitations in terms of synthesis of qualitative and quantitative papers within the concept of thematic analysis. Quality issues were also raised with regard to synthesis and the absence of women's own perceptions within the process. |
| 25 | Scott *et al.* (2004) | Report including comprehensive summary of policy and small-scale interview study with older women (*n* = 5) aged between 52 and 77 years. | To explore older women's experience of DV during their lifetime and impact in later life. | Links evident to the existing literature and policy background. Small-scale empirical data, however, richness in the depth of other data and emerging themes. Limitations and further research in terms of impact on health and the development of services need to be explored. |
| 26 | Straka & Montminy (2006) | Literature review | To present the literature pertaining to DV and elder abuse and to illustrate the gaps that exist between the two bodies of the literature. | This paper provides a comprehensive argument regarding the different (perceived) paradigms (elder abuse and DV) and the authors highlight why neither has been able to respond to the needs of older women who experience DV. The authors draw on key contemporary sources. |
| 27 | Taket *et al.* (2003) | Discussion paper | To identify the issues surrounding screening for DV. | Discussion paper that argues the case for screening for DV. General discussion paper that does not explicitly identify older women. Advocates screening programmes but does not present opposing arguments to this approach. |
| 28 | Wolkenstein & Sterman (1998) | Discussion paper and presentation of two case study examples. | To examine the impact of IPV and impact on health in later life. US-based study. | Provides an overview of the potential health of older women through the presentation of case examples and existing US data. Limited in terms of actual experiences and data provision. |
| 29 | Women's Aid (2007) | Review report. | To review the existing evidence with regard to older women and DV. | Comprehensive – summarises the key literature and studies in this field from an international perspective. Highlights key points and omissions in current knowledge and future research direction. |

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**Table 1** (Continued)

| | Author/date | Type of study/paper | Aim and overview | General comments and strengths and limitations of the paper |
|---|---|---|---|---|
| 30 | Wong *et al.* (2006) | Qualitative study (focus groups) with family physicians (*n* = 54) | To explore gender differences in family doctors attitudes towards DV. Netherlands study. | The study highlighted a number of differences in the attitudes between male and female doctors – the issue of emotional labour among health professionals was also highlighted in the discussion. The limitations of the study are the self selection into the study which may elicit participants that are interested in this area or identify this as an issue for health care workers. Also, the findings do not necessarily correlate to everyday working practice. |
| 31 | Zink *et al.* (2005) | Telephone survey collected self-report information about health and abuse among women aged 55 years and over (*n* = 995) | To identify the incidence and prevalence of IPV in women over 55 years of age within primary care. US-based study. | The survey used a standardised instrument to ascertain levels of IPV. Concluded that IPV an issue for older women but lower rates than younger women. Limitations in terms of self-report and telephone survey – may represent an underreporting of the actual incidence. Use of survey instrument limits data that can be collected in terms of depth and exploration. |
| 32 | Zink *et al.* 2004) | Interview study with 38 women aged 55 years and over | To explore and report on the healthcare experiences and needs of older women who have experienced IPV. US-based study. | Combination of face-to-face and telephone interviews. Analysis and identification of key themes clearly articulated. The use of a semi-structured guide may have hindered the development of the dialogue and responses. Respondents aged 55–90 years and while age highlighted as a limitation no information regarding 'spread' of age. |

DV, domestic violence; IPV, intimate partner violence.

*et al.* 2002). However, it has also been highlighted that professionals may fail to recognise injuries resulting from domestic abuse, for instance attributing bruises and fractures to falls and confusion to age-related conditions (Women's Aid, 2007).

Fisher & Regan (2006) found that older women who reported being subject to domestic abuse have significantly increased risks of reporting depression or anxiety. Furthermore, older women who have experienced domestic abuse at an earlier time in their life, and which may remain unresolved in later life may also experience a number of emotional issues relating to their experiences such as frustration, anger, helplessness, hopelessness and low self-esteem (Wolkenstein & Sterman 1998). In their small-scale study of older women who accessed community mental health centre services Wolkenstein & Sterman (1998) highlighted that due to the gap or delay in time since the abuse occurred, many professionals and family members did not associate the earlier abuse with later health problems. There is a need therefore for healthcare professionals to recognise the distinction between abuse that commences later in life and that which forms part of a previous or ongoing long-term abusive relationship. Older women who have been subject to domestic abuse may have encountered these feelings for longer periods of time and may not feel able to disclose this to others. Acierno *et al.* (2001) suggest that a reluctance to disclose abuse may ultimately lead to emotional isolation and powerlessness which further exacerbates the long-term impact on self-esteem and self-worth as well as physical health.

### Potential barriers to older women reporting domestic abuse

A number of barriers in the reporting of domestic abuse by older women have been highlighted in the literature. One of the major barriers directly relates to the potential consequences of reporting domestic abuse (Morgan Disney & Associates, 2000), for example the fear that disclosure will exacerbate the abuse (Women's Aid, 2007). However, while fear of reprisals may be a generic factor that has the potential to affect women of all ages, a number of specific factors have also been identified as potential barriers to reporting domestic abuse for older women. In a small-scale study, Scott *et al.* (2004), for example conducted interviews with five older women who had experienced domestic abuse and found that the dependency of perpetrators in later life (husband or partner), combined with traditional attitudes towards marriage and gender roles was a significant factor. This placed older women in a dilemma as to whether to stay in an abusive relationship and subsequently to take care of a dependent or to leave. Moreover, due to issues



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related to financial dependency older women may find it more difficult than younger women to extricate themselves from an abusive relationship (Phillips 2000). From a service provision perspective, there is little evidence from within the UK regarding access to services for older women. However, a US study involving focus groups with 134 women, which included older women, identified that older women were not always aware of the existence of services (Beaulaurier *et al.* 2007). The study also found that for those services that were available, many were inappropriate, for instance older women in the study felt that services were disjointed and failed to recognise their particular needs. It also highlighted that the responses of professionals in direct contact with older women at the point of abuse, for example police and emergency services need to be aware of the particular needs and situation of older women. These findings reflect the UK study undertaken by Blood (2004) which highlighted that current service provision, for example refuges, may not be adequately equipped to deal with the physical or psychological needs of older women.

It has also been recognised that the experiences of women from ethnic minorities remain to date largely invisible in studies of domestic abuse among older women. However, as part of a study exploring the assumptions made by service providers towards women from ethnic minority backgrounds, Burman *et al.* (2004) did include the accounts of older women. In so doing they highlighted the cultural misconceptions that exist, which normalise certain behaviours, inhibit recognition and access to services and support. However, taken as a whole the voices of older women from ethnic minorities remain unheard and this clearly represents an additional deficit in knowledge and understanding.

## Potential barriers to the identification and effective management of domestic abuse among older women

From a policy perspective within the UK, there have been recent calls for routine enquiries about domestic abuse to be incorporated into particular health and social care encounters, for example antenatal care (Department of Health 2000a,b). However, while this is an important initiative it still fails to acknowledge or signpost the issues of domestic abuse within the particular context of older women. In Scotland, domestic abuse generally has occupied a more central position in terms of policy developments since the late 1990s (Flueckiger, 2008) with the introduction of a national strategy to address domestic abuse. While Flueckiger (2004) acknowledges that older women have benefited from the general provisions for all women, considerable deficits remain and the specific needs of the older women need to be 'put on the agenda', for example older women need to be involved in the design and implementation of services in the future. In England and Wales, similar national strategies have also recently been developed (Home Office 2000, Home Office & Cabinet Office 1999) but akin to Scotland do not currently specifically acknowledge or address the particular needs of older women. Brandl *et al.* (2003) describe the development of support programmes developed specifically for older women in the US. They highlight that generic support groups may focus on younger age groups and concentrate on issues such as child custody or job training that may not be the most important issues for older women.

Within the literature, there has been considerable debate regarding the effectiveness of screening for domestic abuse across all age groups (Feder *et al.* 2009, Taket *et al.* 2003) including routine screening and case finding but again few have specifically focused on screening for older women. Where this has been explored, particularly within the context of older women, a range of innovative initiatives have been highlighted, though mostly in the US and North America (Scott *et al.* 2004). However, initiatives require agencies and individuals to recognise the issues surrounding domestic abuse and older women before they can be effective. This is echoed by Zink *et al.* (2004, 2005) who highlight that healthcare providers need to be alert to domestic abuse as an issue for older women in consultations as older women are often reluctant to disclose this type of information. They highlight that in addition to the reasons for non-disclosure identified with younger women, they are further compounded with older women through generational factors such as notions of privacy surrounding the home and intimate relationships. This has been further illustrated by Straka & Montminy (2006) who suggest that many of the inherent issues surrounding domestic abuse, for example divorce, are taboo subjects for older women.

Several studies have considered the impact of training or education initiatives for health and social care professionals on the identification and management of domestic abuse generally, for example the development of screening programmes (Cole 2000) and identification and management training (Taket *et al.* 2003). A study conducted in the US among health and social care workers from a number of professions concluded that training exerted an impact in terms of increased knowledge of domestic abuse (Harwell *et al.* 1998). However, the study also found that professionals remained reticent about actually approaching this issue with women. While Moore *et al.* (1998) highlighted that the effectiveness of identification was dependent upon the area within which professionals were working, for example nurses in hospital settings were less likely to ask about domestic

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abuse because of fear of offending patients and others. They were also least likely to have had education and training related to domestic abuse compared with other disciplines. Within the particular context of older women and domestic abuse, given the number of older people who access hospital services, arguably this represents a significant deficit in knowledge and training and an omission in current care provision. In a study of Finnish nurses, Haggblom & Moller (2006) found that those who had encountered personal experiences of domestic abuse were more empathetic and were able to identify gaps in service provision. In a study of general practitioners in New Zealand, Miller & Jaye (2007) found that GPs had difficulty in acknowledging the possibility of family abuse in a family where there were perceived to be no problems of this nature. Meanwhile Wong *et al.* (2006), specifically within the context of older women, found that older patients' willingness to disclose abuse to their GP or other healthcare professionals was related to perceptions of loyalty, for instance the role of a family doctor providing care to both the woman and her partner was seen as a major barrier in reporting partner abuse.

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

## Conclusion and developing policy context

The limitations of this review centre on the issues, as previously identified, relating to the blurring of definitions and boundaries between elder abuse and domestic violence. This arguably presents a key challenge in terms of conceptual clarity as the discourse surrounding older women's experiences of abuse continues to evolve.

As this review has illustrated, to date there has been little exploration of the particular situation and specific health needs of older women in the UK who have experienced domestic abuse (Blood 2004). The reasons for this omission have been clearly articulated and include barriers to disclosure (Acierno *et al.* 2001), failure of professionals to recognise domestic abuse as occurring in this age group (Women's Aid, 2007) and the stereotypical images among professional groups that perpetuate the myth that domestic abuse mainly affects younger women.

The specific impact of domestic abuse for older women has been identified as encompassing a number of factors, for example the effects of long-term trauma alongside mental health problems, for example depression, anxiety and other mental health issues, increased morbidity and mortality (Women's Aid, 2007, Scott *et al.* 2004) and the subsequent long-term consequences on family relationships and support.

Nurses and the wider health community have a pivotal role in both identifying domestic abuse and understanding the particular experiences and needs of older women affected by domestic abuse. Ultimately, it is crucial that services that are responsive to the needs of older women are developed effectively. The review of the available literature has further highlighted that nurses and other healthcare professionals are currently ill-equipped to meet the needs of those who have experienced domestic abuse in general (Robinson & Spilsbury 2008) and more specifically, the particular needs of older women (Women's Aid, 2007). As the preceding discussion has clearly highlighted, there is a paucity of available evidence on the particular needs of older women who have experienced domestic abuse to support practitioners in the practice setting.

The UK policy in this field to date has largely focused on abuse of older women within the context of *No Secrets* (Department of Health 2000a,b). *No Secrets* was published by the Department of Health in 2000 and provides guidance to professional agencies on the development and implementation of policies and procedures to protect vulnerable adults (Blood 2004). Within *No Secrets* abuse is subsumed within vulnerable adult protection and as such it may be argued that the emphasis is towards formal rather than domestic circumstances. Moreover, the lack of conceptual clarity that currently exists with regard to the terminology used, for example how 'vulnerable' is defined lacks specific guidance to professionals. As such, Blood (2004) argues that this 'narrow definition' of vulnerable could discourage older women from seeking support of services. Blood (2004) further argues that while *No Secrets* partially bridges the gap between elder abuse and domestic abuse, the failure to fully articulate the need for services to recognise and work in a more cohesive way, does little to address the gaps in working practices between different professional groups. From this perspective, Phillips (2000) argues that the particular issues for older women who have been subject to domestic abuse need to be brought into 'the mainstream' policy debates rather than remaining a hidden phenomenon. *No Secrets* (Department of Health 2000a,b) is currently undergoing a review and the findings will need to be scrutinised in terms of the contemporary developments in this field.



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However, if unresolved the lack of conceptual clarity at a policy and organisational level that has existed to date, has the potential to exert significant consequences in terms of the continued paucity of service provision for older women. Scott *et al.* (2004), for example highlight the need for development in terms of multi-agency working and that professionals as the 'gatekeepers of services' need to be able to recognise and respond appropriately. They further suggest integrated referral systems and cross-training may go some way to bridging the gaps between domestic abuse and elder abuse services.

The findings of this literature review have formed the basis of a study exploring older women's experiences of domestic abuse, the impact on their lives and health and their encounters with professional agencies. The limited research that has been undertaken to date and the existing literature in this field highlights that domestic abuse exerts a significant impact on the health and lives of older women (Mears 2002). For older women, there are additional challenges in accessing services and receiving appropriate support. A pivotal part of this challenge lies in recognising that domestic abuse among older women is a substantial issue both at an individual and personal level for older women and at an organisational and service level and secondly in developing services and support, which are currently largely absent, to meet the particular needs of this group of women.

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