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Title

Older women, intimate partner violence and mental health: a consideration of the particular issues for health and health care practice

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Summary statement

'What does this paper contribute to the wider global clinical community?'

- Intimate partner violence (IPV) across all ages is now clearly recognised as a global health issue
- IPV impacts significantly on the mental health and wellbeing of older women but this is not always recognised by healthcare and other professionals
- There is evidence that historically IPV of older women has not been clearly distinguished from other forms of violence including elder abuse and family violence.

Abstract

Aims and objectives: The purpose of this meta-synthesis was to explore qualitative evidence in older women with a history of Intimate partner violence (IPV) and their accounts and experiences of mental health.

Background Intimate partner violence significantly impacts the health and wellbeing of women who experience it. However, women who experience intimate partner violence do not form a homogenous group and the effect on older women has not been adequately distinguished. While there is a growing body of evidence to address this deficit, studies to date have tended to concentrate on older women's experiences of intimate partner violence in totality and as such mental health issues have been subsumed as a part of the whole.

Design: Meta ethnographic synthesis of qualitative evidence.

Methods: A systematic search of PUBMED, Cumulative Index to Nursing and Allied Health Literature (CINAHL), COCHRANE , Medline and PsycInfo, Sci was completed. The search included articles published up until the end of December 2015.

Results The review identified that intimate partner violence exerts a significant impact on the mental health of older women. Iintimate partner violence for women in later life is inherently complex, especially where the boundaries of violence and vulnerability have been blurred historically both within the intimate partner violence discourse and through provision and practice.

Conclusions This paper adds to the developing knowledge and understanding of intimate partner violence for older women as a part of the growing body of evidence of the impact of IPV on the health and wellbeing of those who

experience abuse more generally. When age and gender intersect with IPV, there are specific implications and health professionals and service providers need to be aware of these.

Relevance to Clinical Practice Nurses and health care professionals are professionally accountable for the effective management and support of women who have experienced abuse. It is therefore crucial that they are able to understand and identify the possible complexity of presentations of abuse and this includes older women.

Keywords IPV, older women, mental health and well-being

INTRODUCTION AND BACKGROUND

Intimate partner violence (IPV) is now clearly recognised as a global health and societal issue (World Health Organization 2015). The impact of IPV for survivors and their families can be far reaching and includes both immediate and long term consequences for health and wellbeing (Ellsberg *et al.* 2008, McGarry *et al.* 2010). IPV among women generally is not confined to particular individual characteristics, for example, ethnicity, age or social class. However, we still do not know about many segments of the society. Until relatively recently, the experiences of older women within the context of IPV, generally were largely absent from the discourse surrounding IPV (Nägele *et al.* 2010). Historically, for older women, defined variously within the literature globally as encompassing a broad age range of 45 years and over, IPV has often been conflated inaccurately in practice with elder abuse or family violence.

The consequences of such conceptual confusion have arguably been far reaching for older women and include the 'homogenisation' of older women which ignores the inherent issues of gender and power that exist within the IPV discourse (Hightower *et al.* 2006). Moreover, the failure to draw a clear distinction between elder abuse and IPV may result in women's needs not being adequately addressed, resulting in a lack of access to specialist support services for older women, medicalisation of the abuse and the particular issues and needs of the older woman poorly defined within a framework of vulnerability (Scott *et al.* 2004).

Latterly, a number of empirical studies (McGarry *et al.* 2010, Mears 2003, Nägele *et al.* 2010, Scott *et al.* 2004) alongside both qualitative and quantitative systematic reviews of the available evidence have sought to address

this gap (Cook *et al.* 2011, Finfgeld-Connett 2013). While providing a valuable contribution to the growing body of evidence surrounding the phenomenon of older women and IPV generally, with a limited number of exceptions, commentators to date have largely concentrated on older women's experiences of IPV and their descriptions of impact in totality rather than examining in detail a specific aspect of IPV. One such example is the perceived impact of IPV on mental health and wellbeing of older women

It is now well documented within the research literature generally that IPV exerts a significant detrimental impact on the mental health and wellbeing of IPV survivors (Hegarty 2011). Reported negative mental health impacts include anxiety and depression (McGarry *et al.* 2010), post-traumatic stress disorder (PTSD) (Lazenbatt & Devaney 2014), self-harm and substance misuse (Dutton *et al.* 2006). However, while a number of recent studies have sought to examine the impact of IPV for women within the specific context of mental health they have either excluded older women (Ellsberg *et al.* 2008) or have not distinguished older women participants from the wider study sample age parameters (Trevillion *et al.* 2012). Moreover, many of the available studies that have included older women have adopted a quantitative study design and as such are limited in terms of exploring women's narrative experiences of mental health and wellbeing within the context of IPV as described by themselves rather than framed within medical definitions or terminology.

Within the context of service provision for women as survivors of IPV, it has also been reported that mental health services have traditionally focused towards the presenting mental health 'problem' rather than exploring the underlying abuse. For example, service users have been offered medication rather than counselling

support and there has been a 'lack of recognition of trauma or provision of trauma services' (Humphreys & Thiara 2003). From the perspective of older women, there may also be particular barriers, both internal and external, to accessing the requisite services and support for example, (external) perceptions regarding a lack of targeted services (Beaulaurier *et al.* 2007) or (internal) feelings of shame (Beaulaurier *et al.* 2006).

Therefore, taken as a whole, there is a clear body of evidence to suggest that IPV exerts a significant impact on mental health and wellbeing. It is also clear that health and other services and support do not always adequately acknowledge or address the issue of IPV within the context of service provision. In addition, it has been found that IPV is experienced differently for older women for a number of reasons, including longevity of abuse and pervading societal contexts (McGarry *et al.* 2010). Nonetheless, service providers do not always recognise that older women can be subjected to IPV, which consequently has an impact on their experiences with health services (McGarry *et al.* 2010). Ageism within the health care has been identified in other areas (Kydd & Fleming 2015, Lievesley *et al.* 2009, Muir-Cochrane *et al.* 2014). To date, however, there has been a limited focus on the personal experiences of mental health and wellbeing, as distinct from the general accounts of IPV, from the perspectives of older women. This presents a significant gap in current understanding and one that this paper will address. The overarching aim of this paper, therefore, was to undertake a review and meta-synthesis of qualitative evidence in older women with a history of IPV in order to understand factors affecting their health seeking behaviour. Such a qualitative synthesis is essential if we are to improve contextual understanding of older women's experiences of IPV and thus inform service provision.

OBJECTIVES

The specific objectives of this qualitative meta-synthesis were to:

- Highlight the factors that influence health seeking behaviour among older women who have experienced IPV including perceived care experiences
- Identify aspects that may be important to older women when they are accessing services and support generally
- Consider how the findings may impact on the provision of services and responses of healthcare professionals including nurses.

METHOD

A review of the qualitative studies using meta-ethnographic synthesis approach was conducted. Meta-synthesis is a similar process as meta-analysis used in quantitative research (Atkins *et al.* 2008). It is a rigorous approach that allows translation and interpretation of findings from qualitative, ethnographic and interpretive research studies. Meta-ethnography is underpinned in interpretivist paradigm, and goes beyond the analysis of single accounts to identify similarities and differences between accounts. The approach aims to preserve the sense of the account and explain these with the help of selected themes or metaphors (Noblit & Hare 1988). Meta-ethnography involves seven phases which include getting started, deciding what is relevant to the initial interest, reading the studies, exploring how the studies are related, translating the studies into one another, synthesising translations and expressing the synthesis (Noblit & Hare 1988). We followed these phases in developing this review (Noblit & Hare, 1988).

A number of electronic databases were used to conduct the search and these included MEDLINE, Cumulative Index to Nursing and Allied Health Literature

(CINAHL), PsychInfo, Excerpta Medica Database (EMBASE). A search was also conducted using Google and Google Scholar to identify studies not published in indexed journals. In addition, the reference list of each article was scrutinized to identify unpublished studies and grey literature. The search included articles published up until the end of December 2015. The following search terms were used in a number of combinations using the Boolean operators "AND" and "OR": domestic abuse, intimate partner violence, abuse, interpersonal violence Older, elder, aged, experiences, qualitative, women, woman, female*, mental health, mental health services, utilisation, use, barriers, and exclusion.

Inclusion and Exclusion

Empirical studies that explored experiences of older women and IPV generally were included as at the onset it was identified that narratives of mental health may be embedded within wider reports of IPV. The term 'older woman' was defined as 45 years and over. This broad age range was chosen to reflect the definitions used to describe older women within the IPV discourse internationally. To be included in the review a study had to be empirical, qualitative, written in English and published in a peer reviewed journal. Studies, referring to elder abuse or family violence rather than violence or abuse as occurring between intimate partners, or those not specifically age related were excluded from review. Studies that did not make a distinction between IPV and other forms of violence were also excluded. In addition, papers such as reports, case series, scholarly or theoretical papers, editorials, commentaries were excluded.

Study Selection

Figure 1 provides a flow chart for the literature search. The initial search was undertaken independently by two authors; following removal of duplication, 23

papers were identified, after screening of titles and abstracts, 23 articles were retrieved in full text. One of these papers did not meet the inclusion criteria as while the primary focus was on IPV the sample had included older women who had not experienced abuse themselves. Therefore 22 research papers met the inclusion criteria and were included in the analysis. All studies that met the inclusion criteria were then screened, evaluated, synthesised and themed. Methodology used in each study and findings are presented in table 1.

Quality Review and Data Extraction

To review the quality of the studies, the Critical Appraisal Skills Programme (CASP) tool for qualitative studies was used. A data extraction template was constructed and used to record relevant information such as purpose, research design, sampling method, sample characteristics, data collection method, method of data analysis, the results of the study, limitations and comments. Findings are presented under appropriate headings in the following section.

Analysis and Synthesis

As mentioned previously, we used seven stages of meta-ethnographic approach proposed by Nobit and Hare (1988).The approach requires identification and comparison of findings from one paper to another to generate a list of concepts. These concepts were examined to identify similarities and differences in concepts. These concepts were then clustered into three themes, which are presented in this paper. Table 2 presents the concepts and themes identified.

Results

Study Characteristics

The review included 22 qualitative studies published between1996 – 2015. The studies originated from United Sates (Beaulaurier *et al.* 2006, 2007, Seff *et al.* 2008, Teaster *et al.* 2006, Tetterton & Farnsworth 2011, Zink *et al.* 2005, Zink *et al.* 2006a, Zink *et al.* 2006b, Zink *et al.* 2004), Canada (Grunfeld *et al.* 1996, Montminy 2005, Weeks *et al.* 2016), Australia (Mears 2003, Schaffer 1999), UK (McGarry *et al.* 2010), Northern Ireland (Lazenbatt & Devaney 2014, Lazenbatt *et al.* 2013), Israel (Band-Winterstein 2012, Band-Winterstein & Eisikovits 2010, Band-Winterstein *et al.* 2010, Buchbinder & Winterstein 2003), and Hong Kong (Cheung *et al.* 2015). Most of the studies used a descriptive qualitative approach with some using specific approaches such as case study (Tetterton & Farnsworth 2011), oral history (Grunfeld *et al.* 1996) and phenomenology (Band-Winterstein & Eisikovits 2010, Band-Winterstein *et al.* 2010). Data in these studies were collected through qualitative methods including individual interview, focus group discussion, and seminars. The sample size ranged from 2 women (Tetterton & Farnsworth 2011) to 250 women (Mears 2003). Table one provides further details of each study including the methodology.

Themes

The meta-synthesis of the included studies involves a total sample size of more than 900 participants. Analysis resulted in identification of three themes: *unspoken and hidden, the longevity of abuse and the changing nature of IPV over time.*

Unspoken and hidden

For the older women participants, a recurring and dominant theme related to the way in which their experiences of IPV were largely *hidden* from others or, if noticed, remained unspoken. It was clear that this occurred in both the public and private spheres (Teaster *et al.* 2006, Zink *et al.* 2004). Older women spoke of the reasons why they did not verbalise their experiences of IPV and these included feelings of shame (Lazenbatt & Devaney 2014), the pervading societal norms or religious background and the notion that 'marriage was for life' (Beaulaurier *et al.* 2007) – the implication being that they would not leave their partners. Within the context of societal norms, Band-Winterstein and Eisikovits (2010) have drawn attention to the inability of women in their study to 'forgive themselves' or blaming themselves for remaining in the relationship. Of particular significance in this paper was the suggestion by the authors that this, in part, is the result of recognition among older women of the disjuncture between their experiences and the historical societal norms and traditional values compared to those of contemporary society.

For the older women in Beaulaurier *et al.* (2007) study the centrality of the 'unseen' nature of psychological abuse was evident and one participant described that "psychological abuse terminates you". The experience and impact of emotional or psychological abuse was also highlighted by a number of authors (Cheung *et al.* 2015, Lazenbatt *et al.* 2013, Grunfeld *et al*. 1996). Seff *et al.* (2008) highlight that while older women may be exposed to a greater incidence of non-physical than physical violence; they might not acknowledge non-physical violence as abuse and therefore may not seek the requisite help or support.

In a number of studies reviewed the consequences for women in terms of the hidden nature of IPV was that they self-reported poor levels of undisclosed mental health and wellbeing (Seff *et al.* 2008). Moreover, older women were reported as using what has been described as 'pathogenic coping mechanisms' (Lazenbatt & Devaney 2014) for example, the impact of IPV 'symptoms' as an illness and this included the use of prescription/non-prescription drugs and alcohol.

In the studies reviewed, when women did report their mental health issues to professionals the dominant mode of reporting was in many cases to the primary care physician (general practitioner in the UK). In a number of cases, professionals 'medicalised' the women's reported problems. For example, in Schaffer's (1999) study women explained that although they were acknowledged as having a history of mental ill-health they were not asked about IPV, they also noted that they were blamed for their mental illness.

Buchbinder and Wintrerstein (2003) draw attention to the pervasive and enduring nature of the effects of abuse on emotional health and wellbeing after the abusive relationship has ended. They also described older women in their study as feeling a sense of loss. It may be that this is directly related to notions of a loss of personal identity through exposure to IPV over a protracted length of time, as highlighted elsewhere in terms of being 'stripped of identity', 'annihilate your personality' and having to 'rebuild yourself' (McGarry *et al.* 2010, Mears 2003).

The longevity of abuse

It is now acknowledged generally within the literature that older women may either have experienced IPV over the course of a long term partnership or as a

result of entering into new relationships later in life: this point was recognised by a number of authors within the review (Tetterton & Farnsworth, 2011, McGarry *et al.* 2010). However, many women in the studies had experienced IPV for the majority of their adult life through the longevity of their partnership or marriage.

The impact of long term IPV for older women may be in direct contrast to younger women. While all abuse is detrimental to health and wellbeing, it was clear that the cost, in terms of mental health and wellbeing, for older women in our review was greatly felt. For example, Band-Winterstein's (2012) study focused on couples who were still in an abusive relationship and where women described their lifetime of 'fear' and the resultant enduring poor levels of mental health in poignant detail. Buchbinder & Winterstein (2003) also draw attention to the longevity of IPV in terms of the 'ingraining' nature of abuse over time and the subsequent impact on women's health and wellbeing. This was considered explicitly within the context of the abuse compounding feelings of 'worthlessness' or a loss of personal identity among women over time (Beaulaurier *et al.* 2005, Mears 2003).

The changing nature of IPV over time

Within the review a number of authors have drawn attention to the changing nature of IPV that was experienced by older women for example, the transition either in whole or part from physical to psychological forms of abuse (Lazenbatt *et al.* 2013). It is suggested that this is a crucial element of older women's experiences of IPV and one which is central to any health care responses. Particularly if this is then set within the specific context of the significant negative impact of psychological abuse on mental health and wellbeing. In one study, for example an older woman described how her partner, who no longer

physically abused her due to his age and physical frailty, had spat in her ears and the resulting sense of violation that she had felt (Band-Winterstein & Eiskovits, 2010).

Thus, the nature and presentation of IPV can alter in the way it manifests over time. This may be for a number of reasons, including increased frailty of the abuser (Lazenbatt *et al.* 2013). This presents a number of issues and as highlighted by Zink *et al.* (2006b), included an abuser refusing respite care and as such preventing the older spouse from removing herself from the home situation. Worryingly, in Schaffer (1999) study, participants reported being prescribed medication in order to enable them to 'keep fit to support ageing partners'. Band-Winterstein et al (2010) also highlight the narrowing of horizons for action as women age and perceive themselves as having fewer life choices available within their perceptions of decreasing power.

Discussion

The findings of this review have highlighted the particular IPV experiences of older women within the context of the impact on mental health and wellbeing. In so doing, we have attempted to distil the broader body of evidence that has evolved in this field, which, while crucial to illuminating the particular experiences of older women as distinct from that of younger cohorts, has tended to consider IPV in totality rather than focusing specifically on mental health. As such the needs of older women in terms of addressing mental health as well as physical health may not be distinguished nor the complexity of presentations of IPV in later life fully acknowledged. Among the reviewed papers, it was clear that the impact of IPV on psychological health and wellbeing was at the forefront of older women's narratives and that over time this exacted a significant health cost. This was then set against their experiences of encounters with health care professionals. It was clear that while some encounters with professionals were supportive (data not presented), overall either women did not feel able to express their mental health issues or if they did so that these were not acknowledged as such or were poorly addressed. It would be unfair to suggest that all the encounters women spoke of were unhelpful and this is supported in the 'mixed responses' reported by Zink et al. (2005). However, equally there are sufficient accounts within the review as a whole to suggest that older women were not always identified as experiencing abuse (Lazenbatt *et al.* 2013) or if identified have not received appropriate care and support (Beaulaurier *et al.* 2007). It was also clear in the studies included in the review that older women's presentations were not always viewed in terms of their personal life histories, for example treatment of the presenting symptoms rather than underlying cause or that the older women did not express psychological ill-health in medicalised

terms (ref). This has been echoed elsewhere with Cook *et al.* (2011) describing older people who have experienced IPV as potentially lacking "the normative language to accurately convey their abuse" (p. 1078). As such the authors suggest that practitioners need to consider undertaking a more "thorough and ongoing discussion about clients' trauma histories" (Cook *et al.* 2011).

One of the key strengths of this paper is that it has sought to draw together the narratives of older women with a particular focus towards mental health and as such addresses a current gap in the evidence base surrounding the experiences and impact of IPV for older women. However, as previously identified the impact of IPV on mental health for older women as presented from the perspective of older women themselves is very often subsumed within publications that explore the impact of IPV more generally. As such, identifying and successfully extracting those narratives that concentrate on the mental health impact and/or experiences of services can be difficult to achieve.

Conclusion and relevance to practice

IPV exerts a significant and detrimental impact on the lives and health of all women who experience it and this is irrespective of age. However, older women have historically been marginalized or invisible within the IPV discourse as a whole and this has only recently started to change. As highlighted in the introduction, IPV for women in later life can be complex, especially where the boundaries of IPV and vulnerability (of older age) may have been blurred both within the IPV discourse and through provision and practice.

IPV is a global health and societal issue and as such is clearly of relevance for all nurses and health care practitioners. In the UK, recent legislation has helped to focus healthcare professional's attention on the legal duty and professional

responsibility for effective recognition, support and management of those who have or are experiencing IPV. This is particularly relevant to nurses, both in mental health and other fields of practice, as they are often at the front line of care for older women who present to a range of health services from initial assessment through to ongoing support and care provision. This paper, with a particular focus towards older women and mental health, has illuminated this largely hidden aspect of IPV. As such, it will add to the developing knowledge and understanding of IPV for older women as part of the growing body of evidence of the impact of IPV on the health and wellbeing of those who experience abuse more generally.

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Figure 1

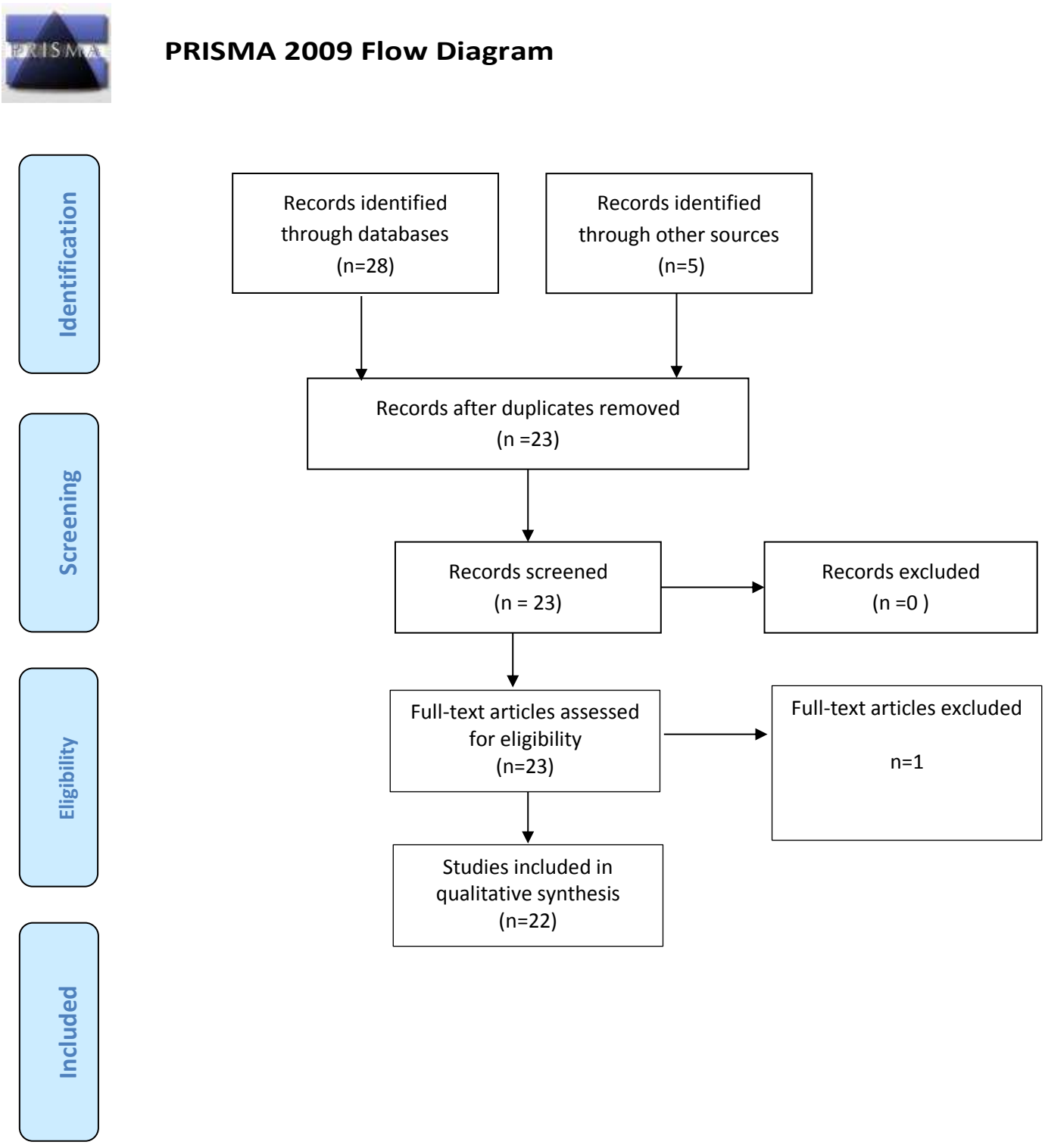
PRISMA 2009 Flow Diagram
Identification
Screening
Eligibility
Included
Records identified through databases (n=28)
Records identified through other sources (n=5)
Records after duplicates removed (n =23)
Records screened (n = 23)
Records excluded (n =0)
Full-text articles assessed for eligibility (n=23)
Full-text articles excluded n=1
Studies included in qualitative synthesis (n=22)

Table 1: Methodology and Findings from Each study

Authors	Region	Aims	Methods	Key findings – related to aim of the review	Emerging Concepts	Themes
Band-Winterstein (2012)	Israel	To explore how older intimate partners living within a lifelong IPV relationship constructed ageing within IPV.	Individual in-depth interviews with 15 older couples.	This study collected the narratives of couples and as such is complex to deconstruct. It is clear however, that older survivors (women) experience poor emotional health and wellbeing 'my nerves [through fear] makes me ill'	Loneliness and isolation in later life	Longevity of abuse
Band-Winterstein & Eisikovits (2010)	Israel	To present the lived experience of older women who had experienced IPV through a phenomenological conceptualisation.	Phenomenological approach. 25 in-depth semi-structured interviews with older survivors (aged 60-84).	The authors highlight the continuing experience of IPV within the context of ageing and highlight issues of growing isolation and physical constriction of space for action due to ageing processes – a sense of powerlessness is explored.	Lifetime of abuse until death	Unspoken and hidden Changing nature of IPV
Band-Winterstein, *et al.* (2010).	Israel	To explore the concept of 'forgiveness' among older women who had experienced IPV.	Phenomenological approach. 21 in-depth semi-structured interviews with older survivors (aged 60-84).	The findings focus on the overarching aim of exploring 'forgiveness' with the authors concluding that social isolation, guilt and the inability to 'forgive themselves'. The authors conclude that the focus of self-blame has clear consequences for practitioners. The authors also note issues related to the way in which IPV is constructed over time.	Impact continues across life course. Self-forgiveness	Changing nature of abuse

Authors	Region	Aim and overview	Methods	Key findings – related to aim of the review	Emerging Concepts	Themes
Beaulaurier et al. *(*2007*)*	US	To explore external barriers to help seeking among middle-aged and older women who had experienced IPV	Twenty-one focus groups with older women (n=134) (45-84 years).	Respondents spoke of emotional abuse as 'psychological abuse terminates you' and that emotional abuse, while unseen, exerted a significant detrimental impact on wellbeing. The authors conclude that as older women may remain in abusive relationships for a number of reasons that practitioners need to 'think outside of the box' in terms of identification and management.	Loss of sense of self identity over time	Unspoken and hidden
Beaulaurier *et al. (*2005*)*	US	To explore internal barriers to help seeking among middle-aged and older women who had experienced IPV	Twenty-one focus groups with older women (n=134) (45-84 years).	A number of women spoke of the exploitative nature of the abuser in exacerbating the 'self-blame' and worthlessness of the woman – resulting what was described by one participant as 'emotional sickness'. The authors suggest that shame and guilt 'ingrained' over time has a lasting impact for older women.	A sense of hopelessness and powerlessness over time	Longevity of abuse
Buchbinder *et al* (2003)	Israel	To explore older women experiences of IPV.	Qualitative in-depth interviews with older women (n=21) (60 – 80 years)	The findings are constructed into four main themes – the issues related to 'suffering' and psychological ill health are explored. The authors highlight that the transition in later life (after the abusive relationship has ended does not automatically signal the end of the impact of abuse – a sense of loss is described in terms of changing identity.	Transition and feelings of hopelessness	Longevity of abuse Unspoken and hidden

Authors	Region	Aim and overview	Methods	Key findings – related to aim of the review	Emerging Concepts	Themes
Cheung *et al.* (2015)	Hong Kong, China	To explore the experience of IPV for older Chinese women.	Mixed methods study – this paper reports two case studies (one of enduring IPV and one of IPV encountered later in life) (63 and 69 years).	The two case studies identify different facets of IPV. The authors draw attention to increasing vulnerability and also the experience of IPV from the two different perspectives.	Increasing vulnerability and impact of psychological abuse	Unspoken and hidden
Grunfeld *et al.* (1996)	Canada	To understand the experiences of older women in terms of the impact of IPV and the implications for practitioners.	Oral history method Small scale study (n=4) (63-73 years).	The study highlighted the shifting nature of abuse from physical to emotional and the longer term consequences of abuse	Long term insidious nature of abuse	Unspoken and hidden
Lazenbatt *et al. (*2013).	Northern Ireland	To gain an in-depth understanding of how older women 'cope' with IPV and how it effects their wellbeing.	Semi-structured interviews with a convenience sample of women (n=18) (age range 53-72 years) who were in or had been in an abusive relationship.	Three quarters of the women in the study self-reported poor mental health and were using 'pathogenic coping mechanisms' including alcohol, prescription and non-prescription medications. While women had accessed general practitioner/practices with physical or associated presentations (panic attacks) they had not been asked directly about IPV. One participant spoke of how her husband had persuaded the GP to prescribe Valium (p16)	Symptoms of abuse as illness not attributed to IPV	Unspoken and hidden The changing nature of IPV

Authors	Region	Aim and overview	Methods	Key findings – related to aim of the review	Emerging Concepts	Themes
Lazenbatt *et al,* (2014)	Northern Ireland	To gain a systematic understanding of how older women cope with IPV and how it affects their wellbeing.	Semi-structured interviews with older women (n=18) (53-72 years).	The findings highlight the self-report among older women of poor mental health and 'pathogenic coping mechanisms' for example, the use of alcohol and prescription and non-prescription drugs/medication.	Pathologising symptoms of abuse	Unspoken and hidden
Mears (2003)	Australia	To gather older women's stories about experiences of interpersonal violence	The use of small group seminars and questionnaires (n=approximately 250) (age range unclear).	The author highlights the recognition that many older women had experienced a lifetime of abuse and that the effects were still impacting on emotional health and wellbeing.	IPV hidden over lifetime	Longevity of abuse Unspoken and hidden
McGarry, *et al.* (2010)	UK	To explore older women's experiences of IPV and the impact on health and wellbeing	In-depth interviews with older women (n=16) (59-84 years).	Findings highlight mental health enduring both within abusive relationships and in later life – these included depression and anxiety. Psychological impact included a sense of loss of identity and guilt.	Hiddenness of abuse and loss of identity	Unspoken and hidden Longevity of abuse
Montminy (2005)	Canada	To explore older women's experiences of psychological violence within intimate partner relationships.	Qualitative interviews with older women (n=15) (60-81 years).	Although there is a detailed discussion of psychological violence, there is little mention of the potential impact on health and wellbeing of the women.	Impact of psychological abuse and access to services	Unspoken and hidden
Seff *et al* (2005)	US	To explore older women's experience of nonphysical abuse and to consider the factors that may prevent women from seeking help	Twenty-one focus groups with older women (n=134) (45-84 years).	The authors highlight the importance of identifying the possible impact of nonphysical violence separately to IPV in totality. The authors also highlight that while nonphysical violence may not be easily identified by professionals, it has significant mental health (as well as physical consequences).	The impact and 'damaging' effect of non-physical violence not acknowledged	Unspoken and hidden

Authors	Region	Aim and overview	Methods	Key findings – related to aim of the review	Emerging Concepts	Themes
Schaffer (1999)	Australia	To identify and explore the needs of older and isolated women who live with domestic violence.	Face to face interviews, focus groups and national phone-in utilised. The data presented in this paper is thought to be related to the telephone interviews (phone in) but this is not clear. 90+ women aged between 50 – 78 years participated in the phone-in.	Theme: *Appropriate responses from service providers*: Women who accessed support through general practitioners acted as gatekeepers, deciding on whether a woman should receive information or help. A number of the callers to the helpline told of how doctors made decisions about them and advised them to take medication 'in order to cope and keep them fit to support their ageing husbands'. Women also spoke of spending a number of years in receipt of psychiatric and psychotherapy but who had not been asked about IPV or had been 'blamed for their mental illness' or labelled as 'problem women or mentally ill'.	Professionals do not ask about reasons for mental health issues	Unspoken and hidden The changing nature of IPV
Teaster *et al.* (2006)	US	To explore the experience and trajectory for older women who have experienced IPV within the specific context of rural environments.	Focus groups with professionals (n=24) and in-depth interviews with older women (n=10) (50-69 years).	The authors highlight a number of factors for example, while many commonalities with younger women, older women's issues compounded by age. Also, in rural environments women were more likely to be part of the wider fabric of society and family ties/support.	Impact of societal ties	Unspoken and hidden
Tetterton *et al.* (2011)	US	To use a qualitative approach to help professionals to understand the 'most effective interventions' when working with older women	A case study approach was adopted with two women (aged 63 and 65 years).	Limited findings explicitly within the context of mental health – one of the case studies identified substance misuse.	Impact of lifetime of IPV	Longevity of abuse

Authors	Region	Aim and overview	Methods	Key findings – related to aim of the review	Emerging Concepts	Themes
Weeks *et al* (2016)	Canada	To explore the needs/resource needs of older women who have experienced IPV within rural contexts.	Interviews with older women (n=8) (50-74 years).	Several of the women in the stiudy were accessing mental health support – however, the focus of the study was towards support needs and the challenges of the rural environment.	Community constraints	Unspoken and hidden
Zink *et al.* (2006)	US	To explore the coping strategies of older women in long-term abusive relationships.	Semi structured interviews either in person or via telephone (n=38) (age range 55 – 90 years).	The findings highlighted that older women experienced mental health problems for example, depression alongside physical ill health but that in the event of the declining health of the abuser, were unable to access services where a dependent spouse would not allow respite to take place.	Power relationships in later life	The changing nature of IPV
Zink, *et al.* (2006)	US	To gain an understanding of the profile of abusers through self-reports of women aged 55 years who have been in abusive relationships since age 55.	Semi structured interviews either in person or via telephone (n=38) (age range 55 – 90 years).	The findings highlighted that physical abuse decreased with age but that emotional abuse continued and in some cases increased. The study also found that while there may be changes in the relationship, for example, physical frailty of the abuser, the power dynamics did not alter. The authors also highlight the importance of recognising that as emotional abuse increases that there may also be an increased risk to older women's health status.	Physical decline of abuser and changing nature of IPV	The changing nature of IPV
Zink et al. (2004).	US	To understand the experiences and needs of older women in healthcare settings	Interviews with older women (n=38) (55-90 years). Combination of face-to-face and	Predominance of reporting physical illness to health care professionals. Approximately half of the women in the study had not disclosed abuse. The authors highlighted that many of the issues	Not supported to disclose IPV when unable to leave relationship	Unspoken and hidden

			telephone interviews.	identified by older women were applicable across all ages but some were compounded by age for example societal norms and increasing social isolation. Responses of health professionals both helpful and unhelpful. Verbal abuse not viewed as legitimate health problem.		

Table 2: Concepts and Themes

Emerging Concepts	Themes
A sense of hopelessness and powerlessness over time	
Hiddenness of abuse and loss of identity	Longevity of abuse
Impact of lifetime of IPV	
Loneliness and isolation in later life	
IPV hidden over lifetime	
Transition and feelings of hopelessness	
Impact continues across life course. Self-forgiveness	Changing nature of IPV
Lifetime of abuse until death	
Physical decline of abuser and changing nature of IPV	
Power relationships in later life	
Professionals do not ask about reasons for mental health issues	
Symptoms of abuse as illness not attributed to IPV	
Community constraints	Unspoken and hidden
Hiddenness of abuse and loss of identity	
Impact of psychological abuse and access to services	
Impact of societal ties	
Increasing vulnerability and impact of psychological abuse	
Lifetime of abuse until death	
Loss of sense of self identity over time	
Long term insidious nature of abuse	
Not supported to disclose IPV when unable to leave relationship	
Pathologising symptoms of abuse	
Professionals do not ask about reasons for mental health issues	
The impact and 'damaging' effect of non-physical violence not acknowledged	
Symptoms of abuse as illness not attributed to IPV	