

The IRIS Project, Manchester Women's Aid: an independent consultation with older clients

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**MANCHESTER
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1 Introduction

1.1 Background

Domestic violence and abuse (DVA) is a universal problem and, globally, the challenge for health and social care services is in delivering an appropriate response (Lombard and McMillan, 2013; Rogers, 2016a). For many communities, DVA is engrained and entwined with pervasive cultural norms in relation to gender roles, marriage and family obligations to name a few. DVA presents in various forms (as physical, sexual, psychological, mental and material abuses) and there is no stereotypical 'perpetrator', nor a predictable group of 'victims' or 'survivors'. Moreover, DVA affects people of all ethnicities, cultures, sexual orientations, gender, socio-economic classes, mental capacities, physical abilities and age at any point during the life-course. Notwithstanding, for some groups in society, such as older people, there has been a continued neglect in research and practice (Zink et al., 2004; Goergen, 2011). Inasmuch, older women constitute a 'hidden group' of victims/survivors (Turner et al., 2010) and this claim most certainly applies to older men too.

When abuse has been identified in an older person's life it is often categorised as 'elder abuse' (Hightower, 2002). This is problematic as it does not recognise the distinct, gendered dynamics of power and control that often characterises DVA (Rogers, 2016a). There are, however, dynamics and impacts that are specific to this group of people as well as a number of complex barriers to making disclosures and seeking formal help. It is important that academics, policy makers and service providers understand the particularity of older people's experiences of DVA as this is acknowledged to be a rapidly growing section of the population. Indeed, in global demographic trends, the growth of the ageing population is 'unprecedented', 'pervasive' and 'enduring' (UN, 2002). Within the UK, it is estimated that by 2030 there will be 51 per cent more people aged 65 or over compared to 2010 figures, and 101 per cent more people aged 85 or over (HM Government, 2013). This trend will have considerable cultural, social, political and economic implications (HM Government, 2013), presenting current and future challenges which will require the State's prioritisation, planning and, more importantly, funding.

In terms of impact, DVA contributes to a wide range of general health issues including stress, depression, anxiety, chronic pain, post-traumatic stress disorder, gastrointestinal and gynaecological problems (Black, 2011; Hegarty, 2011; Warshaw, 2013). In terms of estimating the economic costs to healthcare provision resulting from DVA, this is problematic due to the way in which data is collected and the methodological and definitional inconsistencies in existing studies, but this has been calculated at at £1.73 billion with mental health costs estimated to be an additional £176 million (Walby, 2009). Moreover, in terms of victims/survivors accessing the right form of support, it has been claimed that healthcare clinicians are often the first or only point of contact for women experiencing DVA (Feder, 2009). Conversely, it has been argued, clinicians and healthcare professionals are often reluctant to ask about DVA (Al Natour et al., 2016).

In 2011 Feder et al. (2011) published the results of a randomised controlled trial (RCT) conducted using the IRIS model. IRIS is a:

'general practice-based domestic violence and abuse (DVA) training support and referral programme that has been evaluated in a randomised controlled trial. Core areas of the programme are training and education, clinical enquiry, care pathways and an enhanced referral pathway to specialist domestic violence services' (University of Bristol, 2012).

Conducted in GP practices in London and Bristol, the RCT demonstrated that the IRIS intervention increased the identification and referral of patients experiencing DVA. IRIS was considered to be cost effective and is cited as an example of best practice in various national policy guidance documents (for example, see NICE, 2014).

1.2 Manchester Women's Aid and the IRIS Project

The Pankhurst Trust (Incorporating Manchester Women's Aid, PTMWA) is a women's led organisation whose vision is to ensure that people suffering or at risk of domestic violence and abuse (DVA) receive appropriate support. PTMWA deliver services from their base at the Pankhurst Centre, the former home of Emmeline Pankhurst and her daughters and the birthplace of the Women's Social and Political Union (WSPU) and the Suffragette movement. PTMWA was formed as a result of a merger in June 2014, bringing together two of the leading women's organisations in the City of Manchester. To benefit from and maintain the strong reputation that both charities brought to the new organisation they operate using two trading names: The Pankhurst Centre and Manchester Women's Aid.

Manchester Women's Aid (MWA) has over forty years' experience of delivering specialist domestic abuse services, providing safe accommodation and support to enable recovery from the impact of DVA across the City of Manchester. In addition to refuge and outreach work, specialist services include: IRIS, MiDASS (Midwifery Domestic Abuse Support Service), Independent Domestic Violence Advisors (IDVAs) supporting high risk service users; and the Sahara project for women from BAMER communities.

In Manchester IRIS is a collaboration between health and third sector specialist domestic abuse organisations. In February 2012 Public Health, now part of Manchester City Council (MCC), commissioned IRIS, with Manchester Women's Aid as the specialist DVA service. Since 2015 IRIS has been jointly commissioned, in receipt of continued support from Public Health, MCC, and with the majority of funding coming from the NHS North, Central and South Manchester Clinical Commissioning Groups with additional funding in 2015-16 from Citywide Safeguarding. This funding facilitates all GP practices across the city to undertake IRIS training and have an IRIS service within their practice.

IRIS offers training for GPs and the practice nursing team in each practice whilst the IRIS service is delivered by specialist domestic abuse workers called IRIS Advocate Educators (AEs) who are employed by MWA. IRIS Advocate Educators both co-train GPs and nursing team (along with a GP) as well as offering a specialist service to patients who are referred through the IRIS service. AEs see patients at their GP practice, which enhances patient safety and confidentiality.

In the period from April 2016 to March 2017 IRIS received 481 referrals from GP practices across the city of Manchester. In terms of gender, this includes 9 males, with the majority being female and the age range of individuals is shown below with the majority aged between 18 and 49:

Age	Number	%
16	1	0%
18-29	138	29%
30-39	168	35%
40-49	93	19%
50-59	52	11%
60+	18	4%
Don't know	11	2%
Total	481	100%

Ethnicity was recorded for 300 (of 481) individuals:

Ethnicity	Number	%
Black (British/African/Caribbean/Any)	22	5%
East Asian (Chinese/Japanese/Mongolian/Any)	4	1%
Dual Heritage	10	2%
Other	5	1.5%
South Asian (British/Pakistani/Indian/Bangladeshi/Any)	99	01%
Middle Eastern (Saudi/Iraqi/UAE/Any)	7	2.5%
White (British/Irish/European/Any)	153	31%
Unrecorded	181	37%
Total	481	100%

The University of Salford is working in partnership with Manchester Women's Aid to conduct a consultation of older service users who access DVA intervention via IRIS. This includes service users, both female and male, who are over 50 years of age. This will provide Manchester Women's Aid with the opportunity to evaluate and review its service provision in relation to older people. It is recognised that categorising people as 'older' is problematic as this broad spectrum of ages covers a range of different aspects of life experiences, abilities and vulnerabilities. However, as there is a dearth of existing literature, a starting point is necessary and existing studies which look at DVA in the older age range tend to start at 50 and include midlife (50-65) and later life (65+). Therefore, the age category in this study is congruent with many existing studies.

The following areas were addressed through the consultation:

- Experiences of domestic violence and abuse
- Impact – including short and long-term health impacts
- Barriers and enablers
- Formal and informal sources of support
- Access to support via IRIS

2 Methodology

2.1 Methods

Fieldwork took place in Manchester from April to July 2017. One-to-one interviews were deemed to be the most suitable method as the topic of DVA meant that this project constituted sensitive research (Dickson-Swift et al., 2008; Dempsey, 2016). One-to-one interviewing enabled flexibility and focused on people's actual experiences as well as their beliefs and perspectives (King and Horrocks, 2010). When conducting sensitive research, one-to-one interviewing also facilitates confidentiality and enables the researcher to manage boundaries, emotions and risk (Dickson-Swift et al., 2008; Dempsey, 2016). This research method yields rich and meaningful data, whilst allowing participants to feel safe and empowered which is critical in terms of complementing the ethos of MWA.

The recruitment strategy for all participants was a purposive, non-random sampling strategy. Enabling the recruitment process, the IRIS Advocate Educators acted as *gatekeepers* connecting willing participants with the researcher (Clark, 2011). Inclusion criteria included: aged over 50 years; referral pathway to MWA via IRIS.

Face-to-face interviews were undertaken for convenience and the location was generally in the GP practice with which the participant was registered. This offered a neutral safe space. All interviews were audio recorded. All recordings were analysed using thematic coding and themes are reported below in the findings and discussion section of this report. Adding rigour and integrity, verbatim quotes from the participants have been presented to support the findings and key themes.

A total of 10 people (9 females, 1 male) contributed during the data collection phase. All service users and perpetrators have been given a pseudonym in order to maintain their confidentiality and anonymity. References to location have also been changed. A breakdown of the background of service users is indicated below in Table 1 below.

	Age	Ethnicity	Employment	Health related issues	Children
1	50-60	Pakistani	No	Diabetic, migraine, cholesterol	No
2	70-80	White British	Retired	Undisclosed	Yes
3	50-60	White British	Managerial	Mental health problems	Yes

4	50-60	White British	Homemaker/self-employed	Mental health problems, menopause	Yes
5	60-70	White British	No	Arthritis, gynaecological, problems, gastroenterological problems, mental health problems	Yes
6	50-60	White British	No	Mental health problems	Yes
7	50-60	White British	No	COPD, arthritis, spondylitis, gastroenterological problems, mental health problems	Yes
8	50-60	White British	Managerial	Mental health problems, post-even trauma, gastroenterological problems	No
9	60-70	White Irish	Retired	Mental health problems, alcohol misuse	Yes
10	50-60	White British	No	Mental health problems	No

Table 1: Demographic characteristics of participants

2.2 Ethics

The researcher has experience of research and consultation on ethically sensitive topics (Rogers, 2016b, 2017) and integrates the ethical guidelines laid down by the British Sociological Association, the Social Research Association and the Health and Care Professions Council. In addition, the researcher worked in the DVA sector for many years in Manchester and is a qualified social worker (registration number: M102715). As such, she is adept at negotiating informed consent as well as issues of anonymity and confidentiality whilst embedding the ethical principle of doing no harm. The study was subject to the procedures required by the Ethics Approval Committee of the School of Nursing, Midwifery, Social Work and Social Science at the University of Salford.

3 Findings and discussion

This section is organised in accordance with the main themes that emerged from the data collection process. These themes are: older people's experiences of domestic violence and abuse; impacts and health-related issues; barriers to help-seeking and services; and enablers to support.

3.1 Older people's experiences of domestic violence and abuse

Despite the sample of this project being small, every participant had experienced domestic abuse in multiple forms including physical violence, sexual abuse, emotional/mental abuse, financial/material abuse and coercive control. Three participants described experiencing most of these forms of maltreatment and violence which occurred through the duration of their relationships and, for two women, during the years that they spent bringing up their children.

'I used to get beaten up every time he was in, had a drink. And it was mental as well... he was trying, like, stop my friends from coming to see me... I had a lot of bailiffs coming to the door, because of him, he left a lot of debt here as well he put a portable telly over my head and then walked out.... He was always cheating on me ... he forced sex, he did it a few times.'

'It was very intense from day one...he could get very aggressive and quite controlling... very much emotionally initially and then it became financial and intermittently physical, it built up to the physical, at the end to the journey... he was into his pornography and very demanding sexually and he then wanted to take it to another level of game playing and sulking if he didn't get sex... (after a period of time without regular abuse) but then we were back to the hair pulling and that was the time he raped me then, because I was really reluctant with sex and there was another time then, before Christmas, that I was raped again'.

These excerpts illustrate *intimate terrorism* (Johnson, 2008); a combination of abusive behaviours and maltreatment, including physical and sexual violence, that serves to manipulate, exploit and control maintaining women in a state of fear and tension. Evan Stark (2007) terms this extreme form of DVA as *coercive control* and his influential text sets out a powerful account of how men use these behaviours to control women in their personal life. Coercive and controlling behaviours are now legislated for in the Crime and Disorder Act 2015 which shows how the UK Government has acknowledged that it is not always the physical violence that is most harmful.

Intimate terrorism is not distinct to older people's experiences, but the sustained period of time that perpetrators wielded their control (over twenty years for two of the three women) is notable and key to the many impacts (described below). Like Maggie and Aneeka, Rita had also experienced *intimate terrorism* throughout the years of her relationship (twenty-one years at the time of the interview):

He was controlling ... I've never had a card for 21 years, and he used to just give me money. But I always knew that it was Government money and he was controlling it, and doing what he liked with it... And the way he used to speak to me, [he would say] 'You old cow', he's going to bury me in the back garden; he's going to make men a 6 x 4 and bury me in the back garden... [Recalling an incident] I can't remember why he was in a mood, but he used to drag me, like that, to the door, and try to throw me out, and he threw my handbag outside... he attacked me. I had a bruise on my shoulder here. So I got the Police, because I'd had enough, because he'd actually hit me in front of my son basically, my son was there.'

For Rita a boundary was crossed when her husband assaulted her in front of her son.

Stark's (2007) account of DVA draws together research evidence suggesting that gender inequality is a fundamental, structural problem which enables men to continue to abuse women. Indeed, Maggie and Rita both spoke about how their marriages were very traditional in terms of gender roles and the distribution of domestic labour: Rita said 'I'd have to do everything. He didn't lift a finger' and she described how she had access to a limited amount of money that her husband gave her; her husband controlled the household and her money. After describing a range of debilitating health conditions, Rita said:

'He knew I had a prolapse but he didn't know about all these other problems, because I couldn't fetch myself to tell him because of all the nasty things he said to me, that I've not got long and I thought, well ...It wouldn't have bothered him, because even though I was like this, I was still doing things in the house. He wouldn't help you or anything ...he'd see me lift heavy things, he wouldn't come to help. Any other man would have. He wouldn't do anything for you.'

Other participants disclosed how during their abusive relationships whilst physical violence might have been present at the start, often beginning after their wedding, after it ended, emotional and psychological abuse continued and, for some, increased. Mary (aged 69) illustrated this when reflecting on the forty plus years that she had endured abuse within her marriage:

'The hitting stopped after I called the police out a couple of times. But the verbal and mental abuse continued, and that's worse than getting a belt... he'd call me 'stupid' and 'dumb' and 'blind' and...I remember sitting down one day and thinking 'maybe he's right, maybe I am stupid'. You convince yourself 'well I am stupid'.

One significant change in Mary's marriage had meant that she had recently had some respite from her abusive husband. His health had deteriorated because of the long-term effects of diabetes and this meant that he was becoming less mobile and Mary said 'he's walking slowly, and sleeping a lot and he seems to have gone very calm these last few weeks, so... I don't think he is very well'.

Another participant, the only male in the sample, Brian experienced emotional and psychological abuse only but it took many forms:

'I was experiencing emotional domestic abuse... most of the time it would be snidey comments but the biggest bulk of it is silence... Since [separating] it's been text messages, very rarely do I get...I have a daughter, so and the odd time, she would reply; it wasn't anything positive about meeting my daughter; it just went on and on and on and eventually I just thought, I've had enough and deleted the number'.

In this excerpt Brian illuminates the way in which technology can be used as a mode of abuse; an emerging trend in contemporary forms of domestic abuse and harassment (Woodcock, 2017). The control of time and space are also frequently cited tactics employed by abusers (Sibley and Lowe, 1992) as Mary demonstrates:

'He's a bully. Controlling – a control freak... He dropped me off and said 'when you're finished I'll pick you up'...When I was working some days after I'd finish I'd go to town on the bus, and he'd ring me 3 or 4 times when I was in town. He'd say 'where are you? Can you just pick me up some socks?' So, I'd say 'you don't need socks. You've got a drawer full of socks'.

Mary confirmed that this was an excuse to check up on our her; to see where she was and to control what she was doing.

The oldest participant, Enid was experiencing abuse from her adult son, John, as she noted 'he is verbally abusive'. However, she then described other forms of abuse (intimidation and manipulative behaviours) as John abused the mother-son relationship and Enid's previous kindnesses. He had clearly overstayed his welcome in the family home as Enid explained:

'I've asked him to move out because when he first came in 2002; he said 'can I come and stay for a couple of months and then I'm moving on'. So, I said 'well look, the last time you stayed it didn't work out'. I said 'okay a couple of months' and that was 2002; it is now what? 2017?... I said to him oh last year or the year before, I said to him '[John], you remember you were only supposed to be coming for a couple of months?' 'You say that to me once again' he said 'and I will destroy this house and you won't be allowed to live in it.'

Enid described the erratic, intimidating nature of her son's abusive behaviour:

'Because it's not every single day; it could be a couple of weeks; could be a couple of months, it depends on him. He does contain his temper; he doesn't hit me ... I go to the Co-op bank in town and he said 'I'll give you a lift'. So I said 'oh alright then'; that is one of his good points and I went in, did what I had to do, came back out and when we were coming home, we were coming along Deansgate and he was speeding, so I said '[John], watch the speed. He said something. I said 'you're just like my father'. He said 'don't say that I'm like your father, I'm nothing like him'. I said 'how you would know, you've never met him'... he put his foot down on the accelerator, the car went woomf...it was a good job it was empty; the road was empty.

John also financially and materially exploited his mother:

'He doesn't sort of give me money every week because he's not working anyway. I mean, he's put some money on the mantelpiece today.'

This was not a regular occurrence, but often enough that Enid considered it not to be a significant issue (although she admitted that she was not a wealthy woman). John also used Enid's age-related conditions as a way to exert control:

'[The IRIS Advocate Educator] got some chap to come and put me a handrail up outside. I asked my son to put one up last year and he said 'no, I'm not going to, you don't need it' but I'm alright coming down, it's going up because I've got a wonky knee and if I put too much pressure on it...I can't walk up normally; I've got to go up one leg then the other... I asked [John] last year if he'd put one up and he said you don't need one; I'm not putting one up...He wouldn't put one up, no.'

Another participant, Gina had been married for 29 years and had 7 children with her husband. They had recently separated as after years of coercive and controlling behaviour (Stark, 2007), Gina felt she had no choice as her husband's behaviour had increased in frequency and severity. Gina described the trigger for this as connected to her age. She said:

'The last four years has been horrendous. I've going through the change. And it's hard. There's hot flushes, don't want sex. He doesn't get it. I don't want to be intimate. It's the first time in 29 years. I couldn't be intimate... (Talking about her recent abuse experiences with the GP) The doctor said 'what's driven [Phil] to this'? and I realised it's this. He just flipped. He couldn't understand. So, I was 'this' and I was 'that'. And he does things like he doesn't phone me (he used to phone 5 or 6 times a day).'

Phil had always been controlling; Gina described how he would react if she didn't answer his phone calls, with an interrogation. The menopause, though, had physiological consequences for Gina which seemed to result in Phil's abusive treatment of her. The ways in which he had previously used controlling behaviour (telephoning her several times a day) subsequently changed, and Gina interpreted this (the opposite -no phone calls) as a means to punish her.

Another participant, Aneeka, described how her ex-partner used emails, rather than phone calls, to continue abuse after they had separated as 'he was emailing at two, three, four, five in the morning, begging, begging, begging'. Importantly, the end of the relationship can mark a trigger point for high risk abuse behaviours (Safe Lives, n.d.) and Aneeka's ex-husband also made his physical presence known:

'... he turned up at the hotel. He slept outside on the floor outside the room. He did really odd behavioural things; he would book in the same hotel, phone me up saying I am in the room below you. It really got stalkerish and nasty and scary.'

Aneeka had begun the relationship in her late thirties; she had one previous serious relationship in her twenties, which Aneeka also described as abusive and controlling. Debbie also illuminated aspects of DVA particular to people starting a new relationship later in life. She depicted the way in which her partner of nine years, Ian, began to take her for granted very early on in the relationship:

'He had other children, two old and two younger. And the younger ones, he had a very awkward relationship with his ex and they use to come and stay and it was fine, but I ended up sort of mothering two other children, which you maternally, you are not going to let kids not come and stay and stuff, but it got to the point where the relationship was just really about his children and I was taking time off work in school holidays and stuff and our relationship sort of changed over time.'

Debbie explained that the relationship became just about 'all about sorting the kids out, really' and 'our relationship was just, sort of, you know, teetering on and stuff, but financially, I was getting in such a mess, you know. I was up to here with credit cards, I was up to here with loan'. Debbie took out these loans to help Ian retrain (to the cost of £8,000) and start a new business. Eventually, Debbie ended the relationship and this was the trigger for more abusive behaviours enacted by Ian:

'But I just felt I couldn't just, you know, turn him out on the street. So, like he used to come – he would come here, first thing in the morning, he would be here when I come home from work and I would say to him I really want you – I just need some space and stuff like that. And like he would be here all the time and he wouldn't go... My nerves were in tatters, because he just, you know, he would sit here all night and it would get to where he would down a couple of beers, so he couldn't go because he couldn't drive. And then I would say to him – or he would come and stay at weekend and I just didn't know how to, sort of, approach stuff to, sort of, say that is it. And you know a couple of times, he would come round, he would follow me round the house while I was getting ready for work, one minute he would be shouting and the next minute he would be crying and it wasn't like him but I just felt as if I was being sucked back into stuff, you know, and a couple of times he was violent towards me, and I spoke to the counsellor, I said I am not saying I deserved it, you know, never said that but I could see why he felt so threatened with stuff, because he smashed the bathroom door, which is still broken because I can't afford to get it done.'

Debbie exemplifies one type of behaviour that can occur once a relationship ends, and the danger of this in terms of 'being sucked back' into the relationship.

Debbie also described the other strategies that Ian used to save the relationship:

'Then he started threatening me about work, saying he would get me sacked and stuff like that and stuff had gone because I was on my phone all day. Because he had got my phone logs and saying I was texting. And I was, I was texting my friend, because I just didn't know what to do and like I would stay in work late, and just sit in the car, and like talk to my friends, so he got – it was my phone, but he got my phone logs, because we had a joint account and he was saying that...But the fact that he was threatening to take my job away, if I had no job, I couldn't pay my mortgage, couldn't pay my mortgage, I am out my house, you know and it was that, you know, he said to me I am going to go to work and get you sacked. And do you know what? Before Christmas, he has been to work and sent them a letter...'

Ian's action resulted in a work investigation into Debbie's conduct as he wrote an anonymous letter detailing how she had been using her mobile phone during work hours and that she had passed on confidential information. Debbie had explained to her employers that she was the victim of domestic abuse and acknowledged that 'they are great with me, at work' but formal procedures had to be undertaken because of the nature of the accusations. It had caused Debbie considerable embarrassment, worry and stress.

3.2 Impacts and health-related issues

Participants spoke about mental and emotional abuse as having the most detrimental impact; far worse than the experience of physical or sexual violence. The consequences of living with abuse were wide-ranging and included:

- Social impacts (for example, isolation, estrangement from friends and family);
- Financial impacts (this varied from remaining in the relationship due to financial commitments/shared mortgage, to the prospect of becoming homeless due the end of an relationship);
- Emotional and psychological impacts;
- Physical and mental health impacts.

Most of this section of the report will focus on the last two: emotional/psychological impacts, and physical/mental health. This is because of the connection between health and the IRIS project. All of the participants had been referred to MWA through IRIS and, therefore, had come into contact with their GP in order to trigger the process of a referral to specialist support. There will be also some indication of the financial impacts, however, as this was linked to well-being and mental health by participants.

Participants had visited their GP for a number of health-related reasons. Some, like Maggie, had a number of health conditions: 'I am very ill now, I have got a lot of illnesses. I don't blame him for it, but he has added to it'. Maggie had several stress-related conditions (gastroenterological problems, obsessive compulsive disorder) and poor mental health. All of Maggie's mental and physical health problems had developed over the 20+ years during her relationship. Maggie had other medical problems, spondylitis and arthritis, which she did not attribute to her experience of DVA, but these certainly could have been exacerbated by the frequent physical assaults that Maggie experienced. Maggie reflected on this:

'Got to be connected, hasn't it? I mean, the amount of times that I was [beaten]'.

All, but one participant, disclosed that in relation to their experiences of DVA that they had developed one or more mental health conditions:

'I have depression and I go to a local [health] centre, where they always have signs up if people have depression, panic attacks, anxiety and I was getting a lot of anxiety and panic attacks... where I am up and down, you're not sleeping ...and I've been pouring in sweat. I mean the other day...what day was it? It was lovely and warm. I am sat in the house and I'm shivering.... I thought this isn't normal this. With having depression, I think part of me was thinking well it's depression.'

'Well, I do know it's affected me now, because I've been to the doctors and I had to report this Police incident, and I thought well I'd better go to the doctors because of the bruise. And she turned round and said to me, she said, '[Rita], we know that you've been depressed, we know how you've reacted, how you've spoke to us, but we couldn't do anything until your say-so'. So over the years, here, they've seen depression - little did I know of that, I was depressed - but like I say, everybody has their bad days and their good days don't they? But it was when I came here, they sort of knew, and that was a shock to me, that they'd seen the signs.'

'I went to the doctor's then and he put me on citalopram and sort of propranolol or something, just really because I was shaking like a bloody leaf all the time and I asked – he suggested counselling then and he gave me some information, which I rang'.

'Say I was out in the village, I'd be all worked up, anxious to get back. He'd say 'where have you been''.

[Talking about developing OCD and experiencing DVA] *'It scares you. It scares you. I used to dread him coming home, honestly, I used to dread it. But he is not here no more and it is great. It is absolutely great...Very paranoid as well... I have never been a paranoid person, but he just left me paranoid for some reason.'*

Aneeka described a horrific physical attack on her wedding night in an overseas city which she summed up as 'I ended up with cracked ribs and him strangulating me and smothering me with a pillow'. Alongside physical injuries, Aneeka was left traumatised and she believed that her husband wanted to kill her, 'he said he was going to kill me'. Despite having undergone therapy, Aneeka still had difficulty in talking about this particular night.

In terms of anxiety and restrictions in daily life, this was depicted by Debbie who recounted a conversation held with her CBT therapist:

She went 'well, you know, he sort of – you need to be able to, not deal with it, but you have got to think of coping mechanisms, would you walk out the shop if you saw him? Would you shop somewhere else?' I said 'well, sometimes I think I would go somewhere else, but like last night, after I had been for something to eat, I needed some teabags and I thought well, why can't I go in my local shop? I was in the car, and I thought why have I got to drive a mile along the road, just so I don't bump into him. I could bump into him either way.'

Connected with her debilitating mental and physical health issues, Maggie described how she was unable to be in paid employment, although she hated having nothing to do:

'I don't work no more. I have been stamped unemployable, but I mean I am fighting – they took half of my money off me – I am fighting to get it back, I am waiting for an appeal. But that – I am not even stressing over that. You have just – I need to, like, sort my head out. It is like, I don't know how to explain it ... I don't relax, I have got OCD really, really bad. I don't relax. I don't even come in [the living room] at night. I don't do daytime television either. I don't do it. I look for things to do.'

In addition to mental health impacts, in terms of general well-being, participants described a number of consequences related to their experiences:

'I did drink, very heavily. My sister died and I started drinking vodka...and then I had a fall – I hurt my eye and my knee was fractured... but I'm doing well. I haven't had a drink for 8 weeks. I've had counselling and in a group.'

'He has knocked it all out of me, he knocked my confidence... he has took my confidence, he has left me, when I look at myself, and then he has left me where I don't like looking in the mirror. And he has left me very, very, very, very angry...See, my memory as well ... Because I forget things and I have to write everything down... And I blame – this sounds really stupid, I blame him for that as well. I really, really, truly do.'

Maggie's memory problems could be related to the frequent physical assaults (taking for example, the incident where her ex-partner used a portable television as a weapon aimed at her head), as it is a problem association with the impacts of DVA (Black, 2011).

In the above excerpt, Maggie describes the amount of anger that she feels towards her partner, but she also depicted the way in which this anger flares up in everyday life. Enid too felt angry by her son's abusive behaviour towards her as she described how this is aimed directly at her son: 'I just get mad at him, you know'.

Debbie felt 'embarrassment' because of her partner's actions as these had become entwined in her working life. Reflecting on this, Debbie said:

'So it does feel like a real sense of embarrassment at work, because obviously all the partners know about it. One of the partners ... she is the HR lead and she was really good. She was the one that told me to go to IRIS, because she said I really think you need some sort of counselling, because she said don't take it the wrong but, but you can just see it in your face sometimes, and my nerves and stuff, she said I think – it was after he had sent the letter and everything.'

Debbie also described the considerable amount of debt that she had been left with following the end of her relationship with Ian; some of which (£8,000) she had taken out for him to retrain:

'I have paid off quite a lot of it. I am paying it off – I have probably paid about 20 grand, I think I owe about 30 grand still. I took a loan and my friend just said can't you find out where – you know, because when you got that loan, he must have transferred it somewhere. But I went do you know what? I know it sounds ridiculous, eight grand, I got that amount, all this was just to pay stuff off. So I said but you know what? It is not worth me trying to get it back off him, because he won't give it me back.'

Rita was also left with 'bills, yeah, debt.... I've found it very, very difficult to cope with' and she was left worried that she would lose her house as a result of divorcing her husband:

'If I have to go out of that house, I feel as though I'm sitting there like a piece of meat, waiting to be thrown out, and I really don't want to end up in a one-bedroom flat, because I'm used to living like I have...It's been my home for a long time, and I'll go berserk if I ... I'm not money orientated like him, but I don't know how I'm going to react ... sometimes I have this feeling of going to his solicitors in [town], taking all the papers, the deed and everything and saying, 'Here, you can have it. That's what you wanted, that's what ... you've ruined my life', that's what I feel like doing...I mean, this is the worst situation that I've ever been in in my life.'

Aneeka's story illuminated the financial and material loss that she experienced in terms of the impact on her well-being and independence:

'I was always very independent. And I think that is really significant, because I always thought I was a really strong, independent, girl power...I think it was my own journey in determination and career minded...I always had my own front door as soon as I could afford it and always kind of strongly believed in just being career focused and making money and looking after myself... [But then] I sold my home to be with him, that he strongly encouraged me to do... I agreed to it all and now, it is his house, it is in his name, [with the message] it is nothing to do with you, you can go with nothing, this is my house.'

Aneeka described spending the seven years since she left her ex-husband, Richard, as ones where she was 'rebuilding her life' in emotional, psychological and material terms. She talked about the lasting impact of her abuse experiences, however, she had a chance meeting with Richard recently and it left her 'petrified. Absolutely shaking like a leaf'. Following this incident, a visit to Aneeka's GP led to her referral through IRIS.

3.3 Barriers to help-seeking and accessing services

Before women were referred through IRIS to Manchester Women's Aid, a fundamental challenge presented in many of the participants' lives. This challenge was an initial barrier to help-seeking as participants described the ways in which they did not recognise their experiences as abuse:

'You don't. You just think it is – I am not saying you think it is a norm or it is accepted, but I think because I am telling my story and I get so far and I am thinking that makes me sound really bad, that.'

The lack of recognition of behaviours as abusive, or inability to name domestic abuse, is congruent with other research as one study highlighted how older victims/survivors questioned their experiences and the seriousness of these leading to many who did not recognise their experiences as abuse (Mowlam et al, 2007). Other participants reflected on the ways in which they did not make sense of or respond to their experiences earlier in their life:

'I was totally shocked when [the GP] turned around and said [I recognised you were experiencing abuse] ...she did a medical note for me, and she's put in it, 'This person - meaning me - has been in denial for a long time of depression'...well, it's like I learned to live with it, the abuse... And I coped with it. I mean, sometimes I didn't cope with it.'

'He's just not attacked me a couple of times, he's done it over the years and he's got away with it, because I've never reported it, I didn't know that you could. It's all new to me, this. And the way he was talking to me, I didn't know that was verbal, mental abuse... I just lived with it.'

Brian also described how he did not initially recognise his experiences as abuse, and even when he did, he felt that this was clouded by the fact that he was in a period of conflict with his ex-partner in relation to his contact with their daughter:

'I didn't recognise the abuse at the time. You know, if someone slags you off, you go away but when you've got a daughter you're being knifed to the core...I always put my daughter first. I thought well I'm taking the abuse, even the silence because if I didn't then she'd take it out on me with my daughter. So, a lot of it, I stomached.'

'It was me that wanted to end the relationship, but then I think why did I want to end the relationship? Because I wasn't happy with it. And why wasn't I happy with it? Because I felt trapped. And that, in itself, is quite controlling, to be in that position and I think that, sort of – he has piled the pressure on me.'

Both Brian and Debbie describe feeling a sense of having little agency or control, although Debbie regained this on ending the relationship.

During Aneeka's interview, she began by setting out a chronology of her abusive relationship by stating that it wasn't abusive at first, but only several years in after an incidence of physical abuse resulted in an injury (broken finger). However, in the telling of her story, Aneeka made sense of her experiences and came to admit that her ex-husband, Richard, was abusive from the start as for the first two years he was controlling and manipulative in terms of encouraging Aneeka to move to his home, sell hers and give up her job. During the first two years he was also physically and sexually abusive; regularly dragging her out of bed by her hair on a Friday when he was drunk to begin arguments, and demanding sex (and sulking if he was refused). Aneeka was moving to a position where she understood these experiences to be abusive, but for some time had not considered them to be so in the same way as the very distinct episodes of overt physically violent behaviour which resulted in injuries.

This is unsurprising as Hester and Donovan (2014) persuasively write about pervasive 'the public story' of domestic abuse which considers DVA to be a problem of heterosexual men's physical abuse of women. Whilst all the participants recounted stories set within heterosexual relationships, they did not overwhelmingly centre on physical violence.

Mowlam et al.'s (2007) study, with people in the middle and late stages of their life (that is, people aged 50+), found there are other barriers to speaking out as they may have concern for their family members (children or elderly parents) if they do. Several participants illustrated this:

'I've got a family. My dad's 85; he doesn't want be burdened with this, you know.'

'Only been recently I have told my mum and dad the way I used to get beat up. But he was clever, he used to do it where you couldn't see it. And I would go to my mum and dad's and it would be all oh, you know, everything is fine. But as I say, it is just recently that my mum and dad know what I went through with him. And my mum and dad can't believe it, and my mum even said to me today, [Maggie] why didn't you tell me and your dad? I said, because I didn't want to. You know, I didn't want to. Because they worry about me as it is anyway.'

When Aneeka recounted the terrible attack she suffered on her wedding night in an overseas city, she also reflected on her subsequent decision to fly to the honeymoon destination in another overseas country, rather than leave and return to the UK with her family and friends:

'I should have flown home with the family, my mum was there. My major big thing that I didn't fly home was because I wanted to protect my mum, because ... it was a major thing for her to go to [wedding location], because she had had a clot in her lung. She was lucky to be alive... I could not risk upsetting her ...I did not want to be near this man, I needed to get away from him but my big, major thing was protecting my mum because ...she was vulnerable'.

In this excerpt, Aneeka prioritised the perceived vulnerability of her mother, not seeing her own vulnerability as something which needed to be equally considered. For other participants, it was the emotions of shame and embarrassment that kept them from speaking out:

'I am a fool for sticking by it ... he used to beat me up and then he was sorry. The usual, the sorry and everything is all right for a couple of weeks and then he goes back.'

Brian, the only male in the sample, also spoke about embarrassment and the intersection of gender with stigma:

'Yeah it has been difficult because as I said before, (referring to being a victim of domestic abuse) like when you're a man; what's up with you?'

In the latter part of the excerpt Brian was alluding to the ways in which he perceived that his masculinity would be called into question by friends and others if he disclosed that he was a victim of DVA.

In terms of more tangible barriers, participants' knowledge was scrutinised to establish if they were aware of Women's Aid prior to them having a conversation with their GP and the referral through IRIS. Overwhelmingly, participants indicated that they were unaware of Women's Aid nor that they were eligible for support from specialist services in any form. This question elicited the following responses:

'No. Didn't know anything, no, I didn't.'

'No. I didn't know at all. Didn't know. Didn't know at all.'

Eight out of ten participants did not know that Women's Aid existed. Brian was an exception as he noted that he was aware of Women's Aid, but that he did not that he was able to access service as he thought the service was 'not for men, no'. He added:

'There's a problem there, isn't there, with the name?... Well I don't think many men...that's the worst thing that there are not enough men who access the services because they don't think that they're available for them.'

One other participant was vaguely familiar with Women's Aid:

'Not really. The only reason I knew about it was probably through work, where you see stuff, sort of – I mean, obviously you read a lot about, in the papers and stuff, about domestic abuse and there is this out there and that out there, but I didn't know about this specific organisation.'

In terms of accessing support through services (police, social work services, etc) participants did not report any positive experiences, other than through their GP practices. For instance:

'One time... it was when I was living on [road] and I had got rid of him and he came round, and he had three men in the car. And he, the three men, because it was a cottage flat at the time, the three men, I knew these three men, they came running up my stairs, and started beating me up. And he was sat in the car, my twins ran downstairs, to my neighbour downstairs. She phoned the police. Then they got off – well, they ran out, I ran down the stairs, as best as I could, and he was sat in the car, and they got – the police come and I said I want to press charges. And then when I thought about it, I thought yes, what if they come back – so I dropped them.'

On this occasion, the police did not provide Maggie with further information about DVA or specialist support, such as Women's Aid. It was a number of years ago, however, and is not representative of services today. It is, however, significant as Maggie did not see the police as a source of support for many years. Rita also had an unsatisfactory response from the police after she reported financial abuse by her husband and the police officer that she encountered said he would be in touch with her and pursue matters; this never occurred.

Reflecting on the option of leaving (after more than forty years of abuse), Mary said:

'I did think about it when I was younger, but we always owned our own home. I bought that house in [town] when I was 19 or 20 which was young... Financially we've always been OK... I was a cleaner for [hospital] for 23 years... there was always money around.'

Mary's lifestyle and homeowner status was a barrier to her leaving an abusive relationship. A different barrier was illuminated by Debbie, a working woman, as she was unable to so easily access some of the interventions and group-based support offered by MWA during daytime hours. Debbie explained:

'[The IRIS Advocate Educator] got in touch with me and I went and met her and we talked about various support groups and one of them – where she thought would be helpful. One of them was the CBT counselling, which took a little while for me to get an appointment, only because they were ringing and saying well, can you come tomorrow but I work and as much as work are yes, that is fine, I couldn't just drop everything to go to an appointment if I have got – you know, and you think you can, but I can't. It is not doable, as much as my manager will say it is absolutely fine, there has got to be a manager on site, so if she as on holiday – and a couple of times I said look, Friday is my day off, I can come any time on a Friday and then they would phone and go can you come tomorrow. I am like it is Tuesday, no.'

Asked if she would have sought out some form of support if a referral through IRIS had not occurred, Debbie said:

'I am not sure. Because I don't know whether I would have thought about it'

As such, even when people recognise and name their experiences as abuse, they do not always think to seek out specialist support, or do not think that they may be eligible.

3.4 Enablers to support: referrals via IRIS

One participant, who had not previously heard of Women's Aid, described how having her GP ask the question about DVA had enabled her to access support:

'I think something needed to give – it was my doctor ... that said to me have you ever been in an abusive relationship, and she said it when I was like that with my hands (described wringing her hands) ... very good, Dr [Jones], because I was doing all this, I am anxious anyway, but she picked up on it and I had told her.'

Participants clearly benefitted from the support and advice received from MWA following their referral via IRIS and often it served to reinforce their own decision-making and actions:

'Sometimes I sit of a night and I am on my own, and I am never, ever sorry that I have split up with him, never, you know financially, the stress that he has caused me – sometimes I am a bit worried of a night time, but then I think get a grip. And even at my age, that I am not – I am still glad I have done what I have done. I wouldn't have wanted to carry on the rest of my life, long or short, with somebody that I didn't want to be with and I was feeling more and more manipulated by.'

Another participant, Debbie, was registered at and worked in a clinical practice which had access to IRIS (although the participant lived in a neighbouring town):

'I have been there 11 years, 12 and I think [my manager] feels a sense of not duty to me, but a sense of, you know... she knows that she can access places like IRIS and stuff. Because my GP is in Manchester... so I just kept my same GP (whilst living in a different town).'

In addition, as she worked in the healthcare field, Debbie felt that she was better positioned in terms of being encouraged and being able to access interventions:

'I have got a few, sort of, healthcare professional friends, if you like... he knows what has happened and he was like yes, you need to give IRIS a crack at, because there is support out there, so yes, so for that I think it was more that I found out through my own colleagues.'

In this sense, Debbie's employment situation had enabled her to access MWA IRIS where she admits above that she does not know if she would have done so had it not been for her colleagues' encouragement. Enid reflected on how she felt after seeing the IRIS Advocate Educator allocated to her: 'I feel good after I've spoken to her and I can fight the world, you know'.

Aneeka described IRIS and MWA as 'fabulous'; she had not heard of either and was unaware that any support for survivors of DVA existed. She wanted to share her experiences to help others:

'There were some group sessions coming up that they said might be helpful and even me sharing my story... I do feel passionate of giving something back, to share my journey, you know, I would have liked to have given something back.'

Having someone to be a listening ear and show empathy was considered to be important and an invaluable aspect of the support offered:

'It's nice to know that someone listens'

Another participant described receiving an empathic, supportive service in her own words:

'So I see [the IRIS Advocate Educator]; she is lovely, like yourself. Because you have got to be lovely people to do this work, you have got to be.'

In terms of receiving a person-centred approach, it was not just the staff of the IRIS Project who were commented on but the need for continuity of support, or rather continuity of the person. Maggie felt that this was important as 'you go, you get comfy with somebody and then when you next go, it's someone new' (Maggie was referring to counselling in a different healthcare service as an example of the value of continuity and relationship-building).

Moreover, the participants described a myriad of ways in which they felt that they had benefit from the support they had received following their IRIS referral. This included: emotional/psychological support; signposting; and advocacy. For example, earlier in this report, aspects of Debbie's story are presented in terms of the harassment that she's experiencing as her ex-partner has written anonymous letters to her employers. Illustrating the flexibility of support offered by MWA, Debbie's IRIS Advocate Educator has written a letter to help her employers to understand the ways in which DVA is being perpetrated through the continued harassment and controlling behaviours of Debbie's ex-partner. Debbie explained:

'I think once they sort of – because of the letter [the IRIS Advocate Educator] wrote to them... she sort of said that this is just another sort of way to manipulate the situation and that, you know, he is still trying to, sort of, have control over what I am doing. And she was really good, because she said do you want me to get in touch with your manager...'

Another participant, Rita, was unaware of Women's Aid but had been enabled to access legal advice and support following her referral to MWA IRIS:

'The doctor had given me all the leaflets, who I could contact, but I did not know about IRIS until the doctor mentioned it, 'Phone them up, [Rita], because I said to her, 'I don't know what I'm going to do, I have no money, I'm going to have to fight for it, go to court and fight the divorce myself'. And with me being so stressed, it didn't register at first, but in her way; she was saying phone that number, she was trying to help me, and now I understand, she was helping me. And as soon as I phoned them up, they got me a solicitor.'

There were suggestions in terms of how the IRIS service and MWA could conduct more awareness-raising for women, like Rita - that is, older people and those who are not aware of DVA services – as one woman felt passionately about promoting the services and also raising awareness of the problem of DVA:

'It needs to be out there. It needs to be so women know that there is hope; there is something there and for me, it needs to be out there, as I say. You know, people need to know. Women don't know that there is people like [MWA]. They don't know. I mean, I didn't...'

In addition, another participant noted the changing environment in professional practice in terms of identifying and responding to DVA. As such, she highlighted the value of IRIS:

'Fabulous we are educating GPs, because the GP couldn't help me seven years ago, he just sat and looked at me and referred for normal counselling and then he lifts me off his list and I never even got the counselling. And I just thought again, it is not meant to be. Oh yes, he did offer me anti-depressants as well, because I was a bit upset and emotional in his surgery, so he didn't know how to manage that, so he offered me antidepressants to calm me down'.

4 Discussion and conclusions

Whilst this project was conducted on a relatively small-scale basis, the participants represented a range of backgrounds and offered a diversity of experiences, usefully illuminating some of the central issues for older victims/survivors of domestic violence and abuse. Some of these issues make the problem of DVA in older people's lives distinct from those of young people; a few overlapped with dominant stories of abuse and violence from more 'mainstream' victims and survivors (heterosexual women of childbearing age). For example, the issue of health and disability was a recurrent theme, appearing in several of the participants' stories. It was, however, represented in different ways. Some participants spoke about their partner's illness as giving them respite from abuse and maltreatment (Mary) whilst others talked about their own debilitating health conditions as having resulted from years of abuse (Maggie).

Rita spoke about how she hid the extent of her health problems from her husband as she considered that he would use any knowledge about her in a derisive, negative way and Rita did not want to give her husband any more 'ammunition'. In terms of the existing literature on older people and DVA, particularly in studies which include people in later life (aged 65+) there is some discussion of how health and disability intersects with older people's experience and how the demands of caring or need to be cared for can be present (Rogers, 2016a, 2016c). The connections with caring were not present in these forms within the narratives collected in this project, but health and disability featured frequently and is certainly a factor which influences the impacts of living with DVA in positive and negative ways (as shown in the excerpts above).

Of particular interest was the ways in which abusers used a variety of means to exact abuse and maltreatment and this included more contemporary forms of abuse which use technology (mobile phones, social media, and so on) (Woodcock, 2017). Emails and texts were cited by two participants which were used as abusive and controlling tactics employed by their former partners; with one participant noting how the frequency and content of emails bordered on 'stalkerish'. These narratives demonstrated an overlap with younger people's experiences of DVA where technology is perhaps more obviously connected with the lived experience of survivors particularly in light of new forms of online misogyny such as sexting and revenge porn (Jane, 2016). The participants here did not experience these overt modes of abuse, but the use of technology in post-relationship abuse for Brian and Aneeka had a considerable impact on their well-being and feelings of safety.

Financial and material abuse was part of the abuse experience for several participants who admitted that they had been left in considerable debt or who had relinquished their own finances and material resources to their abusive partner and found themselves 'starting again' (Rogers, 2016c). In addition, the participants raised issues more frequently cited as problems for older people, for example: adult child to parent abuse; and triggers being age-related (menopause). In other ways, the participants were typical of victims/survivors whatever their age and background. For instance, three out of ten had recently left relationships in which *intimate terrorism* (Johnson, 2008) had endured the length of their long-term relationship. Some participants noted how emotional and psychological abuse was more difficult to live with than physical assaults. All-in-all, the message from the data collected in this project is that older people's experiences of DVA can mirror those of younger people but there are some additional factors (disability, economic stability, duration of abuse in long-term relationships) that need to be more carefully considered as part of the abuse dynamic, often acting as a barrier to leaving and accessing help.

Moreover, as one of the distinct barriers to help-seeking and accessing support is the lack of ability to name abuse, in addition to the lack of knowledge about Women's Aid and specialist support, there is a clear implication in terms of awareness-raising and education. However, it could be argued that this greater awareness is also needed to help practitioners understand how DVA in older women's lives is not the same as elder abuse (Rogers, 2016c). These issues are qualitatively different as DVA integrates power and control dynamics which are gender-based and interplay significantly with gender inequality. It is also important to note that there was one male in the cohort, and that older male victims/survivors could now be considered to be a 'hidden group' worthy of further attention (Zink et al, 2004; Turner et al., 2010).

In light of the considerable health and mental health impacts of DVA noted in the above findings section, a reconsideration is called for in terms of understanding older people's needs and the impact of longevity and the influence of duty and commitment in abusive relationships. This is particularly salient for those women who have finances tied up with their partnerships and marriages. However, in terms of the support that they have experienced via IRIS, none of the participants reported anything other than helpful, respectful and empathic support from the point of their initial discussion with the GP to their interactions with the IRIS Advocate Educators.

Indeed, the way in which GPs had noticed participant's anxiety and stress, and subsequently asked about DVA, was seen as very positive indicating a person-centred approach that was not tied to assumptions and judgements that related to age. Thus, participants spoke about having felt listened to and heard. Following a referral to IRIS, participants all reported positive impacts within or resulting from their interactions with IRIS Advocate Educators and support staff. As most of the participants in this project had no prior knowledge of Women's Aid, or their eligibility to receive support in relation to their DVA experiences, it is clear that had the IRIS Project not existed in their GP practices, it is unlikely that they would have accessed the support that they had.

This is important particularly in light of the way in which older victims/survivors have been described as 'hidden' and 'neglected' in policy, practice and research (Zink et al, 2004; Goergen, 2011). As such, the IRIS Project is a key facilitator in enabling older people to access support for DVA in the city of Manchester. This is important as a report by SafeLives (2016) noted how victims frequently cite healthcare professionals as their preferred professional in terms of who they would like to speak to about DVA with the report advocating that DVA specialists should be located in all hospitals (SafeLives, 2016), and GP practices argued Feder (2009; Feder et al., 2011). Finally, one of the limitations of this project was that the participants had not engaged with other interventions offered by MWA such as groupwork, and therefore it is not possible to comment from the data if there is a need for age-appropriate provision and interventions, as has been suggested in other studies of this kind (see Rogers, 2016c) and another study may wish to explore the efficacy of existing provision in this context. Notwithstanding, it is clear – in congruence with existing empirical work – that the IRIS Project in Manchester represents good practice (NICE, 2014) but more importantly offers a bridge across the gap between older victims/survivors and existing service provision.

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