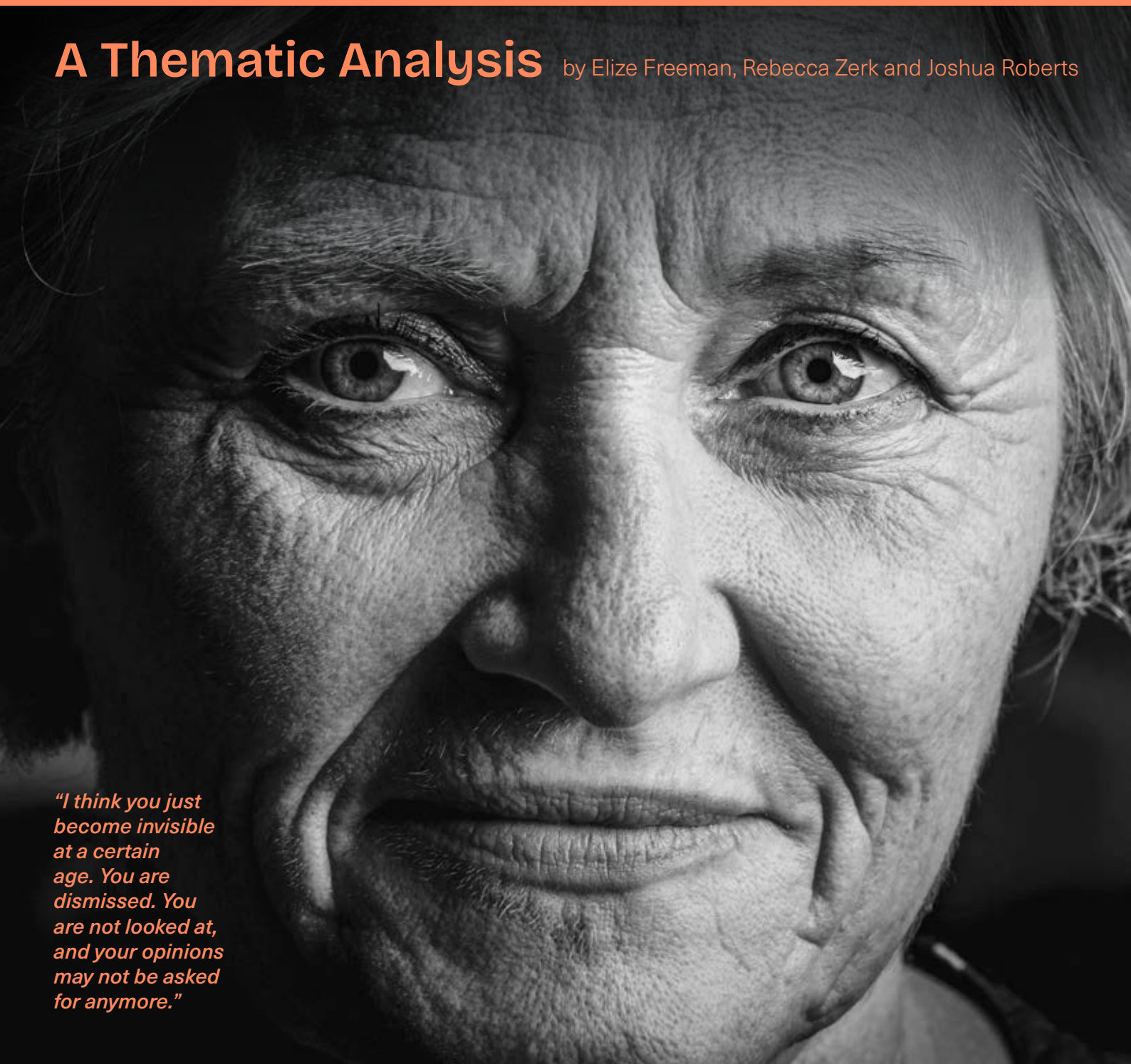
Report: Understanding the Experiences of Older Victim-Survivors

A Thematic Analysis

by Elize Freeman, Rebecca Zerk and Joshua Roberts



"I think you just become invisible at a certain age. You are dismissed. You are not looked at, and your opinions may not be asked for anymore."

Content Warning

This report discusses the lived experiences of older adults who have experienced abuse from intimate partners or adult family members. Some readers may find the content distressing or triggering. Please proceed with caution if these topics are sensitive or harmful to you.

Acknowledgements

The production of the guidance was funded by the National Lottery Community Fund. We are grateful for the support provided by our funders in our commitment to promoting the needs, rights and entitlements of older victim-survivors of domestic abuse.

Dewis Choice

Based at Aberystwyth University's Centre for Age, Gender and Social Justice, the Dewis Choice Initiative has co-produced a pioneering grassroots intervention, developed with the community to support older victim-survivors of domestic abuse by partners, ex-partners, or adult family members. Combining direct service delivery with ground-breaking research, Dewis Choice leads the first prospective longitudinal study exploring decision-making in later life. By listening to older victim-survivors, the Initiative identifies what works and how services—including housing, policing, health, social care, and the third sector—can improve their responses. This rights-based, research-informed model ensures support is tailored to the specific needs of older adults.

Dewis Choice
Centre for Age Gender and Social Justice
Aberystwyth University
Penglais
Aberystwyth
Ceredigion
SY23 3FL

Contact

choice@aber.ac.uk

Authors

Elize Freeman, Rebecca Zerk, and Joshua Roberts

Foreword

Older victim-survivors have poor visibility within domestic abuse research, policy, and service provision. Historically, the focus of domestic abuse research and survivor engagement has been on younger adults, with older people's experiences underexplored (Bows et al., 2025; Welsh Government, 2018; Wydall and Zerk, 2017). Consequently, the evidence base and response to older victim-survivors of domestic abuse are underdeveloped. Research by Dewis Choice highlights the systemic barriers older victim-survivors of Intimate Partner Abuse (IPA) and Adult Family Abuse (AFA) face to accessing support, with their experiences often overlooked or homogenised under the broad term 'elder abuse.' This categorisation fails to acknowledge the diversity of multiple generations of older adults, their varied lived experiences and individual support needs.
Previous exclusion of older adults, particularly for those aged 75 years and above, in domestic abuse data collection has resulted in significant gaps in understanding the prevalence and nature of experiences of older victim-survivors of domestic abuse in later life. In the 2024 Crime Survey for England and Wales, 4% of adults aged 60-74 years and 2.1% of those aged 75 years and over reported experiencing domestic abuse in the previous 12 months. However, the prevalence of domestic abuse in later life is likely to be underestimated, as many older people do not recognise their experiences as domestic abuse or report abusive behaviours. Despite accounting for 27% of domestic homicide victims (Office for National Statistics, 2021), victims aged 60 years and over remain largely overlooked in high-risk domestic abuse responses (SafeLives, 2016). This invisibility, combined with underreporting and persistent gaps in data collection, highlights the urgent need for more robust evidence on domestic abuse in later life.

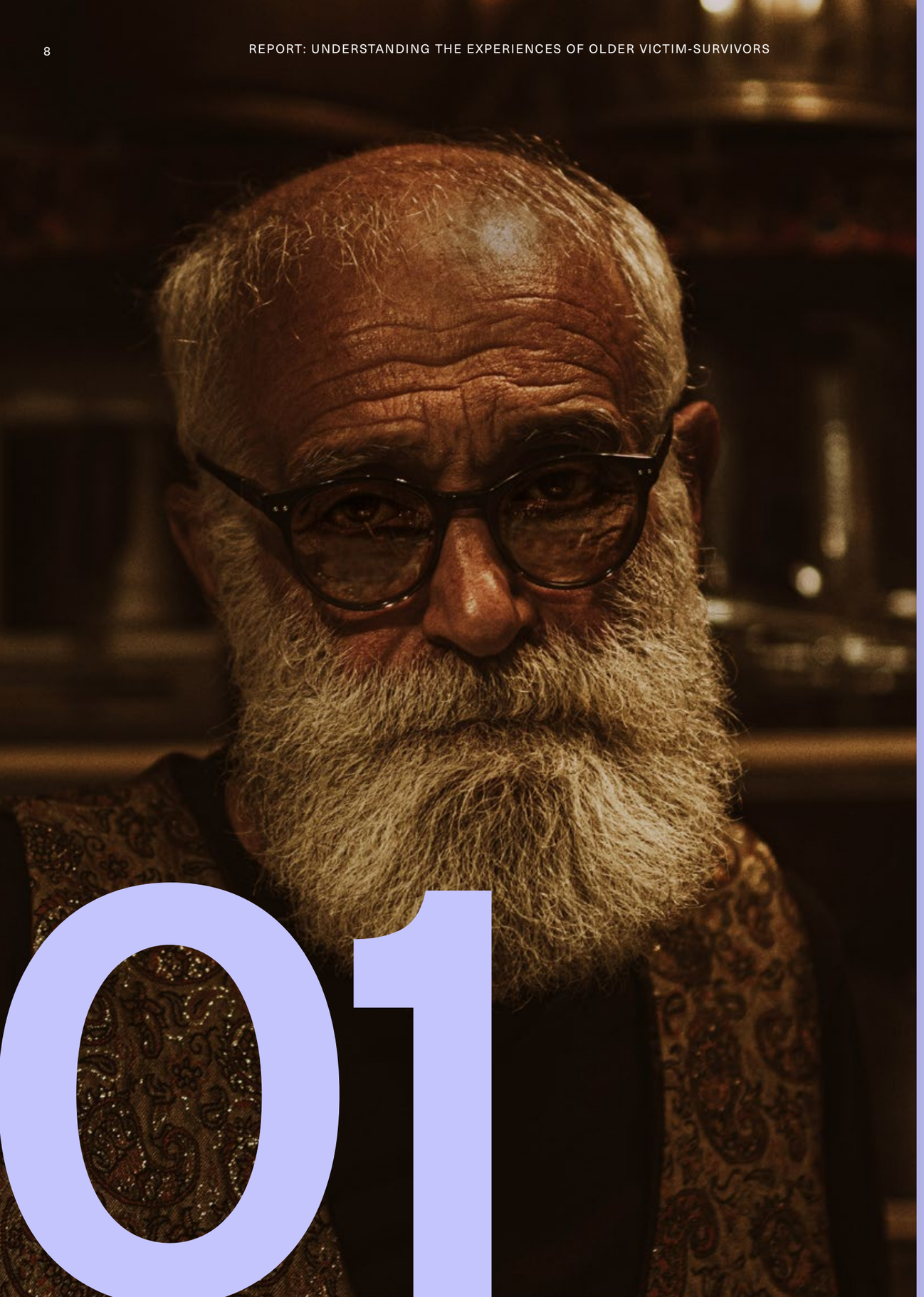
The lack of research, policy focus, and tailored services for older adults experiencing domestic abuse has led to their ongoing invisibility in support systems and public discourse (Zerk, forthcoming). Without improved data collection, age-inclusive risk assessment tools, and greater recognition in policy and services, older victim-survivors of domestic abuse will continue to face barriers to seeking help and support. Addressing these gaps is key to ensuring equitable access to protection and justice for all victim-survivors, regardless of age.

This report aims to contribute to improving research and organisational responses, drawing on the lived experiences of older women and men who have experienced domestic abuse from intimate partners and adult family members. The report will explore how organisations can be more inclusive in creating safe spaces within their interactions and engagement with older adults: relational safe spaces, that can better facilitate older victim-survivors to disclose abuse and seek ongoing help and support.

We extend our deepest gratitude to the older victim-survivors who shared their experiences and contributed towards the development of this report. We also extend our thanks to the Welsh Government VAWDASV Blueprint Older People's Workstream for their ongoing support and to the organisations that provided the good practice case studies included in this report.

"Age-appropriate support can lead to significant improvements in safety and wellbeing for older victim-survivors. Intensive, longterm recovery work is crucial to address the harm caused by domestic abuse, providing older victim-survivors with the tools to rebuild their lives with confidence and independence.

Establishing and promoting safe spaces is essential for enabling older victim-survivors to speak openly, seek support, and reclaim their lives free from coercion and control." (Elize Freeman, Co-Lead of Dewis Choice)



01

Executive Summary

This report, ‘Understanding the Experiences of Older Victim-Survivors: A Thematic Analysis’ explores the lived experiences of people aged 60 and over who have experienced domestic abuse from intimate partners or adult family members. Research conducted by the Dewis Choice Team at Aberystwyth University, identifies how systemic failings and social attitudes combine with personal barriers to make older victim-survivors largely invisible within current service provision.

Barriers to Support

Older adults face a dual set of barriers: structural and individual.

- Structural barriers dominate. Most services, campaigns, and assessment tools are designed with younger adults in mind, leaving older people excluded. Referral pathways are often unclear, fragmented, or absent—particularly for older men. Limited accessibility (physical, sensory, digital) and a lack of targeted outreach mean many do not know support exists or cannot reach it. Professionals frequently address symptoms (e.g. anxiety, isolation, health problems) without asking about underlying causes, leaving abuse undisclosed. Ageism in policy, practice, and data collection further reinforces invisibility.
- Individual barriers compound these systemic issues. Many older adults struggle to recognise their experiences as abuse, shaped by generational norms of privacy and self-sufficiency. Fear of retaliation, shame, embarrassment, and self-blame deter disclosure. Some worry about burdening their families or believe they will not be believed, particularly where perpetrators are respected in the community.

Together, these factors create an environment where opportunities to seek help are rare, fragmented, and often missed.

The Need for Safe Spaces

Older victim-survivors stressed that safe spaces are not just physical locations but relational environments where they feel protected, listened to, and believed. Safe spaces must be age-inclusive, accessible, and proactive, designed to overcome the structural barriers that prevent older adults from engaging with traditional services. They include:

- Confidential and private settings where older adults can speak without fear of repercussions.
- Trusted relationships with consistent professionals who provide stability and continuity.
- Informal community contexts where disclosure feels less intimidating than in formal appointments.
- Relational safety—professionals who demonstrate respect, empathy, and accountability, enabling older people to explore choices without judgement.

Safe spaces, whether physical or relational, are the foundation upon which disclosure, trust, and recovery are built.

The Importance of Professional Curiosity

A recurring theme is that disclosure rarely happens spontaneously. Older victim-survivors often do not know that they can—or should—discuss abuse with professionals. Practitioners across health, social care, housing, and community services must therefore:

- Proactively ask direct but sensitive questions about home life and wellbeing, rather than waiting for disclosure.
- Make it clear that disclosure is appropriate within their role, signalling readiness to listen and respond.
- Use accessible, empathetic language that avoids alienating terminology and builds understanding over time.
- Explain confidentiality clearly to build trust, particularly in small communities where fears of gossip or reprisal are acute.

Professional curiosity, combined with safe relational spaces, transforms fleeting encounters into genuine opportunities for disclosure and support.

Priorities for Services

Older victim-survivors consistently prioritise:

- Proactive, personalised contact from services, rather than reliance on self-referral.
- A single, trusted point of contact to navigate fragmented systems and reduce the strain of repeated disclosures.
- Practical support with housing, finances, and everyday tasks alongside emotional support.
- Opportunities for community connection, tackling the loneliness and disconnection that often follow abuse.
- Long-term, trauma-informed recovery support, recognising that the impact of abuse and trauma often spans decades.

Conclusion

The evidence shows that structural failures in service design, policy, and practice— exacerbated by individual fears and generational norms—are the key reasons older adults remain invisible within domestic abuse responses. Without proactive engagement and safe, relational spaces created by professional curiosity, many older victim-survivors will continue to suffer in silence. Age-inclusive, trauma-informed approaches are urgently needed, underpinned by practitioners who are explicit in their readiness to listen, ask, and respond.

02

The Development of Safe Spaces for Victim-Survivors of Domestic Abuse

The notion of a safe space for people experiencing domestic abuse has broadened markedly in recent decades. Once centred on refuge and specialist services, it now spans community, retail, and digital settings that reduce barriers to support and reflect a multidimensional view of safety.

Against this backdrop, this section briefly covers the evolution of safe spaces, the concepts shaping contemporary understandings of safety, and the need for approaches that recognise the distinct experiences of older victim-survivors.

The concept of a 'safe space' for victim-survivors of domestic abuse has evolved considerably over recent decades. Traditionally, provision centred on physical safe spaces, most notably domestic abuse shelters providing secure accommodation partnered with specialist support. These spaces were facilitated by specialist organisations and accessed through established service pathways.

In recent years, safe space provision has diversified, reflecting both a recognition of the barriers to accessing specialist services and an expanded understanding of what safety entails. Innovative initiatives have extended safe spaces into community-based, retail, and digital environments, increasing accessibility for individuals who may be unable or unwilling to engage with conventional services. Examples in the UK include:

- **UK Says No More campaign:** a partnership with pharmacies, banks, and selected Jobcentres, offering access to private consultation rooms for individuals experiencing domestic abuse.

- **Ask for Angela:** a scheme adopted by bars and other public venues enabling patrons to discreetly seek assistance when they feel unsafe or at risk.

- **Community-based safe spaces**: such as Islington Council's partnership with the charity Hestia, which trains 'ambassadors' in public spaces, including libraries and local businesses, to provide immediate support and signposting to services.

- **Digital safe spaces:** including mobile applications such as Bright Sky, which provide discreet, secure access to information, resources, and reporting mechanisms.

These initiatives illustrate that physical safe spaces are no longer confined to formal service environments but may be embedded in everyday settings, thereby offering more immediate and discreet access to safety and support. They also extend to peer-led support groups and therapeutic landscapes, which play a crucial role in providing emotional safety—spaces in which victim-survivors can share their experiences without fear of blame, disbelief, or stigma:

"Safe spaces extend beyond professional specialist provision to include peer-led support groups and therapeutic

landscapes which play a crucial role in offering emotional safety, allowing survivors to share their experiences without fear of blame or stigma." (Campbell et al., 2004)

Defining Safety: 'Safe From' and 'Safe To'

Contemporary understandings of safe spaces extend beyond the physical to encompass emotional, psychological, and social safety. This can be conceptualised through two interrelated dimensions: **safe from** and **safe to**.

- **Safe from** refers to protection from immediate and ongoing threats, including physical and sexual violence, emotional abuse, financial control, and coercive or controlling behaviours. It may involve secure housing, legal protections, and confidential services that prevent the perpetrator from exerting continued influence or control.
- **Safe to** describes an environment in which victim-survivors feel able to disclose abuse, seek help without fear of judgement, and make decisions about their lives without the threat of reprisal or coercion.

While safe from and safe to describe essential dimensions of safety, they do not fully capture the relational dynamics through which safety is enacted and sustained. Relational safety, foregrounded in both trauma-informed (Sweeney et al., 2016) and feminist practice (Kelly, 1988; Stubbs, 2002), draws attention to the interpersonal connections that enable trust, recognition, and empowerment. Alongside these two dimensions, the concept of a relational safe space highlights how supportive and accountable relationships are integral to victim-survivors' experiences of safety. Jauniaux and Lawford (2024) define relational safety:

"Relational safety refers to interactions where individuals feel secure, respected, and free from various forms of harm."

(Jauniaux and Lawford., 2024)

A relational safe space is one where trust, respect, and mutual recognition are actively cultivated, enabling individuals to feel not only protected but also genuinely heard and understood (Ali, 2017; SAMHSA, 2014). This goes beyond the absence of threat to include the presence of affirming, reliable, and non-judgemental relationships. Within such spaces, people can express vulnerability, explore choices, and engage in dialogue without fear of dismissal or harm. Importantly, relational safety requires clear boundaries and accountability, ensuring that interactions uphold dignity, promote autonomy and foster empowerment.

Safety also operates at a deeper, more internalised level, incorporating the concept of ontological safety—a sense of stability and trust in oneself and the world (Dupuis and Thorns, 1996; Giddens, 1991; Zerk, 2025):

“A sense of ontological safety—where individuals feel free to engage cognitively, emotionally, and socially—is fundamental to reclaiming personal autonomy and wellbeing.” (Lewis et al., 2015)

This highlights the importance of fostering not only external security but also the internal conditions necessary for victim-survivors to re-establish agency, rebuild self-worth, and re-engage with everyday life following trauma. Yet, the ways in which such safety is experienced are not universal but shaped by social location and identity. As the Roestone Collective (2014) observes:

“What may be considered safe for one individual may not be for another due to factors such as age, gender, race, sexuality, and disability.” (Roestone Collective, 2014)

Conceptions of safety cannot be understood as universal, nor can they be transposed unproblematically across the life course. Research with younger victim-survivors provides important insights, but these cannot simply be generalised to older populations without accounting for how ageing intersects with structural inequalities. To overlook this complexity risks reproducing ageist assumptions and erasing the diversity of older adults lived realities.

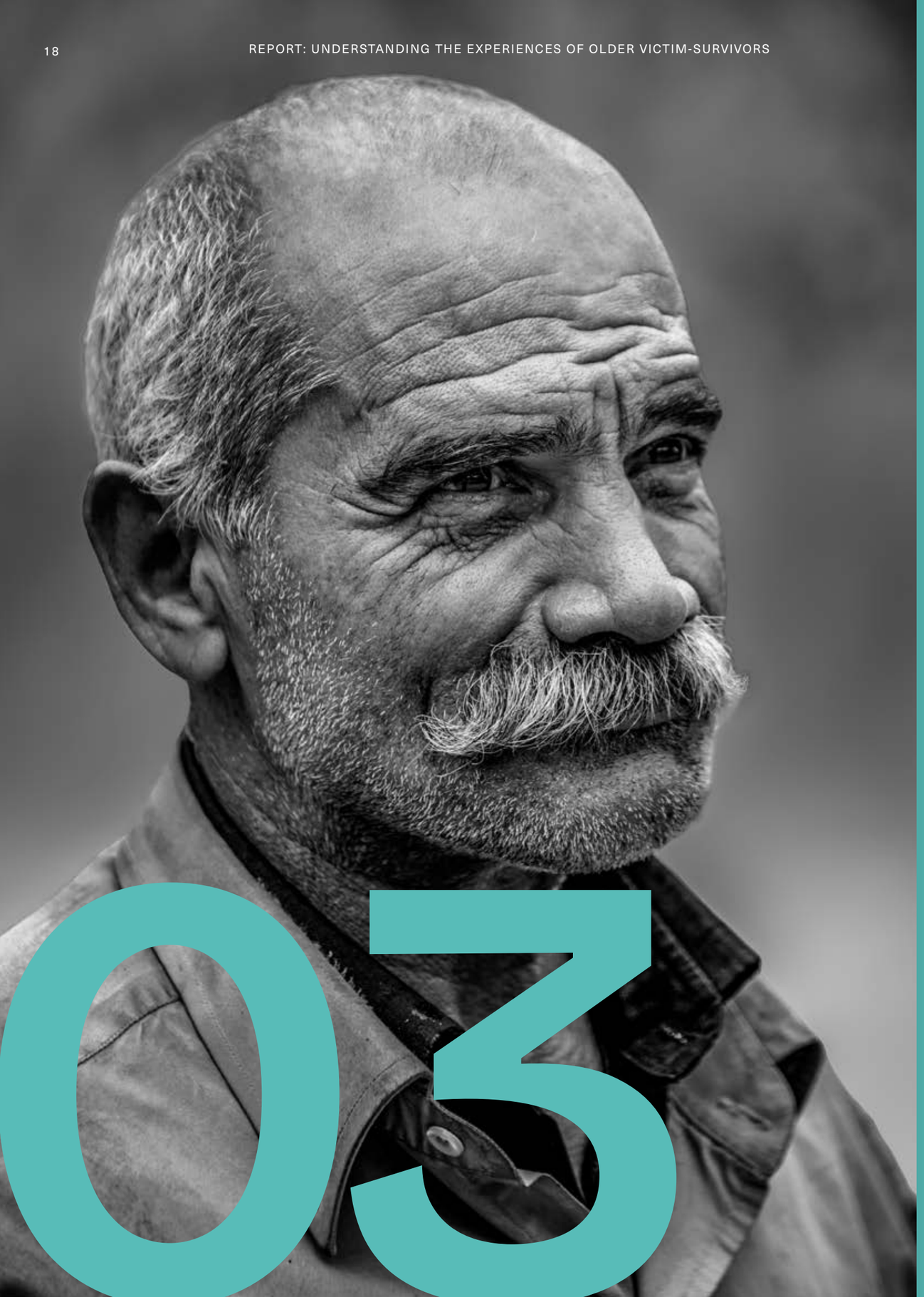
Addressing Gaps: Safe Spaces for Older Victim-Survivors

Despite the diversification of safe space provision, a significant gap remains in relation to spaces that are designed with, and for, older victim-survivors of domestic abuse. Age-related factors such as reduced physical mobility, sensory impairments, and increased reliance on carers may constrain older adults’ ability to engage with community-based initiatives that are often oriented towards younger or more mobile populations. Similarly, a lack of familiarity with, or access to, digital technologies can prevent older people from benefitting from the growing number of app-based and online safe spaces (Rush et al., 2025).

These challenges are compounded by the absence of targeted awareness campaigns for older adults, resulting in limited knowledge of specialist services tailored to their needs. Consequently, many older victim-survivors are left at a disadvantage in their ability to identify and access the support available. The combined effect of limited physical and digital accessibility, alongside insufficient targeted outreach, underscores the need for age-appropriate safe space initiatives that address the specific barriers faced by this demographic.

Finally, there is a knowledge gap in the evidence base itself. Much of the research and service design around safe spaces draws on the experiences of younger victim-survivors. While this has generated valuable insights, it has also normalised a “one-size-fits-all” model of safety that inadequately reflects the diversity of older adults’ lived experiences. Greater attention to older people’s voices is needed, not only to adapt existing models of provision but also to reconceptualise what safety means in later life.

This report seeks to contribute to addressing this gap by exploring older victim-survivors’ perspectives of safe spaces and examining how relational safe spaces can be created within organisational settings.



03

Research Overview

This report presents the findings from a thematic analysis of a study conducted as part of the Welsh Government Violence Against Women and Girls Domestic Abuse and Sexual Violence (VAWDASV) Blueprint Strategy 2022 to 2026: Older People's Needs Workstream. The aim of the workstream is to ensure service responses are age-appropriate and that harms are prevented and addressed for older people in Wales.

The study was carried out by the Dewis Choice Team, at The Centre for Age, Gender and Social Justice, Aberystwyth University. The team explored the lived experiences of older victim-survivors (aged 60 years and above) of domestic abuse, with the aim to improve accessibility and effectiveness of services for the older demographic.

Study Sample

This report draws on semi-structured interviews conducted with nine older victim-survivors of domestic abuse. To facilitate discussion, participants were asked six open-ended questions designed collaboratively by members of the VAWDASV Blueprint Older People's Needs Workstream. At the time of the interviews, all participants were receiving support from Dewis Choice, a service specialising in domestic abuse support for older people.

Victim-Survivor					Perpetrator
Gender	**Age**	**Physical disability**	**Mental health condition**	**Relationship to the perpetrator**	**Gender (including where there was more than one perpetrator)**
Female	73	Yes	Yes	Wife	Male
Female	75	Yes	Yes	Wife	Male
Female	75	Yes	Yes	Wife	Male
Female	60	Yes	Yes	Mother	Male Female
Female	76	Yes	Yes	Wife	Male
Female	63	No	Yes	Mother	Male Female
Male	68	Yes	No	Father	Male
Male	84	No	Yes	Father	Male
Male	68	No	Yes	Partner	Female

Victim-Survivor Characteristics

Of the nine older victim-survivors interviewed, six were female and three were male, with ages ranging from 60 to 84 years. Participants represented a range of relationships to perpetrators, including intimate partners (husbands, wives, partners) and family members (parents). Additional vulnerabilities further characterised the sample: the majority reported either a physical disability (n=6), a mental health condition (n=8), or both (n=7). These intersecting characteristics highlight the complex interplay of health, dependency, and abuse in later life.

Perpetrator Characteristics

Across the nine cases, there were 11 perpetrators, comprising eight males and three females. In two cases, the victim-survivors experienced abuse from more than one perpetrator.

Perpetrators included intimate partners and adult children. Some perpetrators (n=6) were reported to have additional vulnerabilities by the victim-survivors, including dementia, learning disabilities, learning difficulties, and substance and/or alcohol addiction. These factors may intersect with patterns of abuse and present additional challenges for victim-survivors and the organisations seeking to respond effectively.

Data Sources and Scope

The findings of the report are drawn primarily from the semi-structured interviews with the nine older victim-survivors described above. The findings are also informed by thematic insights from a broader group of older individuals who have engaged with Dewis Choice as part of ongoing research (2015-present). The wider sample experiences help to contextualise and reinforce the themes emerging from the interviews.

04

Findings: The Challenges

Older victim-survivors of domestic abuse face complex, intersecting barriers that restrict their ability to seek help and be recognised within support systems. These challenges arise from personal, social, and structural factors shaping how abuse is understood, disclosed, and responded to in later life. They are compounded by gaps in existing services, where limited awareness, inadequate signposting, and a lack of tailored provision leave many unsure where to turn.

This section examines these barriers, drawing on victim-survivors' accounts to show how they intersect and shape pathways to support.

Barriers to Seeking Help

Older victim-survivors of domestic abuse face multiple, systemic barriers to accessing services and support. Systemic ageism in particular hinders help-seeking for older victim-survivors and limits recognition of their experiences. The following quote describes one older woman's difficulty in acknowledging domestic abuse in later life:

As you get older, it's even more difficult to admit to yourself that something is happening. It's easier in some ways to sort of bury your head in the sand and get on with it. I think that's what I did for years. I just thought, well, what can I do about it? (Older female, IPA)

The nine older victim-survivors in this study identified eight key barriers that prevented them from accessing help and support. The table below summarises these barriers, along with descriptions and selected quotes from victim-survivors to highlight their lived experiences.

Barrier	Description	Survivor Quotes
Not Recognising the Abuse	Older victim-survivors often did not identify their experiences as domestic abuse, which limited their recognition of themselves as victims. The terminology of domestic abuse, along with associated support services, was not perceived by participants as relevant or applicable to their circumstances.	*"I bet there's loads and loads of older women still in abusive relationships now who wouldn't even begin to think that this was a domestic abuse situation. Well, as I say, I didn't." (Older female, IPA)*
Invisibility in older age	Victim-survivors discussed age-related stigma and a form of invisibility, where domestic abuse in later life is rendered unexpected or even unimaginable. Such narratives can intensify isolation, as older victim-survivors may feel that their experiences are illegible within dominant social discourses of ageing, which tend to emphasise dependency, respect, or decline, rather than ongoing risks of abuse.	*"You wouldn't expect this [domestic abuse] at my age... not old age like me." (Older female, IPA)*
Loneliness & Isolation	Victimisation among older people was frequently accompanied by heightened levels of social isolation. Participants were unaware that their experiences were shared by others of a similar age, which deepened feelings of loneliness and reinforced the sense of being cut off from potential sources of support.	*"I didn't know other people had this issue. What a horrible life I've had, but I had no idea." (Older female, IPA)*
Self-Sufficiency	Older victim-survivors often drew on a strong generational ethos of self-sufficiency, which shaped their belief that they should cope with abuse independently. This emphasis on independence acted as a barrier to seeking external support and reinforced the sense that older victim-survivors had to endure abuse in isolation.	*"I've always been an independent person... I would have soldiered on." (Older female, AFA)*

Barrier	Description	Survivor Quotes
Lack of Knowledge	Awareness of support services was limited among older victim-survivors, reducing opportunities for engagement and access to help. Participants perceived existing services as not tailored to their needs as older victim-survivors, with male participants in particular reporting difficulties in identifying and navigating support systems.	*"I didn't know what services were available." (Older male, AFA)*
Fear	For older victim-survivors, fear operated on multiple levels: (1) Older victim-survivors were fearful they would not be believed, particularly when the perpetrator held a respected position within their community. (2) Older male participants described a fear of being blamed or dismissed because of their gender, which further deterred disclosure. (3) For older female participants, the fear of retaliation from the perpetrator carried heightened weight. Concerns about serious injury were intensified by disability, frailty, or age-related health conditions, which made the potential consequences of physical assault especially severe.	*"Nobody would believe me anyway because he [perpetrator] helps people [as a profession]." (Older female, IPA)* *"But you just get the feeling that because you're the man, you're going to get the blame for it." (Older male, IPA)* *"If he had found out I was talking about him, he would have erupted into a horrendous temper." (Older female, IPA)*
Shame & Embarrassment	Older victim-survivors often internalised their experiences, with feelings of shame and embarrassment acting as barriers to disclosure. For older male victim-survivors in particular, feelings of shame were heightened by social expectations around masculinity and self-reliance, making it especially difficult to acknowledge victimisation or seek support.	*"I myself, I would say that people are embarrassed when things like that are happening in your life. You try and keep it quiet and, um, try and live with it and hoping that things will either improve or go away" (Older female, IPA)*
Self-Blame	Some older victim-survivors believed they were personally responsible for the abuse and would adapt their own behaviour to try to minimise the harm. This sense of self-blame acted as a significant barrier to seeking support, reinforcing experiences of isolation.	*"You feel that you're causing the problem. I felt maybe it was my fault."(Older female, IPA)*
Lack of Clear Referral Pathways	Older victim-survivors encountered a lack of clear referral pathways, which created uncertainty about how to access appropriate support. Older male participants highlighted this gap even more strongly, noting that services appeared ill-equipped to support men and that the absence of obvious referral routes left them particularly unsure which services they could access.	*"No one knew what to do with me." (Older male, IPA)*

Taken together, these barriers highlight how the interaction of personal beliefs, social circumstances, and structural limitations within support systems shapes older victim-survivors' help-seeking behaviours. Consistent with existing research (e.g., McGarry et al., 2014; Wydall and Zerk, 2017), the findings illustrate that age-related perceptions—such as the belief that abuse does not occur in later life—combine with generational norms of self-reliance to reduce the likelihood of disclosure (Zink et al., 2004). Barriers such as shame, self-blame, and fear reflect both internalised stigma and the anticipated negative responses of others. At the same time, systemic obstacles, including limited awareness of services and unclear referral pathways, indicate gaps in provision for older victim-survivors, particularly older men. These interlinked challenges not only delay access to support but may also exacerbate the duration and severity of abuse, highlighting the importance of age-appropriate, accessible, and non-stigmatising interventions.

Perceptions of Limited Opportunities to Seek Help

In addition to the barriers outlined above, older victim-survivors described having limited viable opportunities to disclose abuse or seek assistance, whether through formal services or informal personal networks. For some, the constraints of mobility, health, and social isolation restricted face-to-face interactions where disclosure could occur. Even where opportunities existed, a lack of trust, fear of repercussions, and uncertainty about the appropriateness of seeking help from certain sources further limited engagement. Informal networks, such as friends, neighbours, or extended family, were often absent or perceived as unsympathetic. At the same time, formal services were seen as inaccessible, unresponsive, or ill-equipped to address the specific needs of older adults. This scarcity of safe and trusted avenues for disclosure meant that opportunities to seek help were rare, fragmented, and often missed entirely.

Family

Participants were often reluctant to disclose abuse to family members, particularly adult children. While a small number reported receiving positive responses and ongoing support following disclosure, the prevailing view was that sharing abuse experiences would burden relatives who already faced their own life challenges and responsibilities. Concerns about transferring emotional distress or disrupting family stability further deterred open discussion.

As one participant explained:

“I didn’t want to burden them. They’ve [adult children] already got enough on their plates.”

(Female, IPA)

Even after leaving the perpetrator, some older victim-survivors remained hesitant to seek emotional or practical help from adult children, fearing they would add to their children’s strain.

“Well, I suppose I could ask my boys [sons], but I don’t want to burden them with it because I don’t want them to go through what I went through.” (Older female, AFA)

Friends

Friends were rarely viewed as appropriate sources of support. Many participants believed that friends would be unable to offer solutions or that disclosure would not lead to meaningful change. Feelings of fear, shame, and embarrassment—expressed by seven of the nine participants—further limited disclosure, as did a lack of close friendships.

Exceptions occurred where trust and reciprocity of support were established in friendships. Two women described confiding in friends with whom they had mutually supportive relationships:

“My friends lean on me, so I feel like I can lean back.”

(Older female, IPA)

Community Members and Safe Spaces

Disclosing abuse to broader community members was widely viewed as undesirable due to embarrassment and fear of becoming the subject of gossip.

“It’s really embarrassing. You just think you don’t want them [the wider community] to know what’s going on.”

(Older female, IPA)

“Everybody knows everybody in the village, you know? And if I said anything about my husband to somebody, they would let it slip in all probability. And my husband would hear about it, and he would go absolutely ballistic.”

(Older female, IPA)

Various community-based safe space initiatives and support options were explored with participants, such as “Ask Ani” in pharmacies, “Ask for Angela” in bars and venues, dedicated ageing services and other community-based services. Awareness of community-based safe space initiatives was low, and most participants had not considered these as viable routes to support.

Specialist Domestic Abuse Services

Where participants were aware of specialist domestic abuse services, many felt these were not designed with older people in mind. Language and imagery in outreach materials were seen as targeted at younger victim-survivors, creating a sense of exclusion.

“The whole image of domestic abuse is violence and young women. It’s not psychological abuse, it’s not coercive control, and it’s not older women. And, if you see any sort of programmes about it or any sort of awareness stuff about it, it’s always young women, and it’s violence.” (Older female, IPA)

“Even now, on social media, it’s all women suffering domestic abuse. Nothing for men at all.”

(Older male, IPA)

Health Professionals

There is also a common assumption that older adults disclose domestic abuse to their GPs. However, participants, particularly the older males, reported feeling uncomfortable about discussing abuse with their GPs. Older victim-survivors cited several barriers, including:

- Lack of continuity in seeing the same GP, which limited the ability to build trust and openness.
- Limited/short appointment times, which provided no space for discussion beyond the immediate health concern.

Although participants described frequent interactions with healthcare professionals which were related to the physical and mental impacts of the abuse, they noted that health professionals often focused on addressing the symptoms rather than exploring the underlying causes.

Police

Involvement of the police was generally seen as inappropriate or unnecessary unless physical violence had occurred. This narrow view of what constituted a police response limited reporting of other forms of abuse, such as coercive control or economic abuse.

“There wasn’t really a reason for me to call the police, I mean he didn’t hit me, he wasn’t violent or anything like that.” (Older female, IPA)

Across the sample, there was evidence of high levels of fear, criminal damage to property and breaches of non-molestation orders — none of which were considered police matters by the participants.

Taken together, these findings show that the barriers outlined earlier in this report were reinforced by the lack of safe and trusted avenues through which older victim-survivors could disclose abuse. Even when opportunities were available, a lack of trust, fear of repercussions, and uncertainty about whether particular sources were appropriate often prevented disclosure. Informal networks—such as friends, neighbours, or extended family—were absent or frequently perceived as unsympathetic, while formal services were seen as inaccessible, unresponsive, or ill-suited to the needs of older adults. This scarcity of trusted pathways meant that opportunities to seek help were rare, fragmented, and often missed entirely, leaving many older victim-survivors isolated in their experiences of abuse and suffering in silence. Older adults involved in this study believed that addressing this gap requires a proactive approach from services and professional, ensuring that opportunities for disclosure are actively created by asking direct, sensitive questions and signalling that support is available and appropriate for people in later life.

05

Findings: The Opportunities

Older victim-survivors described how safety within professional settings was shaped less by the physical environment and more by the quality of everyday interactions. Feeling able to disclose abuse depended on trust, confidentiality, and whether professionals appeared approachable and responsive.

This section covers how older adults experience opportunities to disclose, the conditions that make professionals feel like safe points of contact, and the barriers that persist even during regular engagement, drawing on older victim-survivor accounts to highlight what supports—or inhibits—open conversations about abuse.

Creating Safe Spaces and Opportunities to Disclose

Older victim-survivors in this study described how the walls of a service environment alone rarely defined their sense of safety within professional support. Instead, it was built—or eroded—through the everyday interactions that shaped whether professionals felt approachable, trustworthy, and responsive to their concerns.

This theme examines older victim-survivors' perspectives on how professionals can create environments in which older people feel able to disclose abuse and access support. Participants were invited to reflect on the kinds of services in which they felt comfortable engaging, the characteristics that made professionals approachable and trustworthy, and the barriers that persisted even in the presence of regular professional contact. Their responses highlight both the perceived limitations of current practice and the opportunities to develop approaches that actively encourage disclosure.

Confidentiality

Confidentiality emerged as a central concern and a prerequisite for disclosure. Creating opportunities for older victim-survivors to speak privately was seen as essential. Because older victim-survivors are more likely than younger victim-survivors to remain living with the perpetrator and be accompanied at appointments, many reported carefully managing what they disclosed in the presence of partners, adult children, or even supportive family members. Several participants stressed that the opportunities to disclose could only occur when professionals deliberately arranged a private space away from family members.

In cases where older victim-survivors felt able to disclose abuse in the presence of supportive family members, they commented that they would not disclose the full nature and extent, especially if the abuse were sexual in nature.

Even when opportunities for privacy were presented, many participants expressed deep anxiety that what they disclosed may be shared with their families or local communities. This fear was heightened in smaller community settings, where

pharmacists, GP receptionists, or nurses were often also neighbours or acquaintances. One older woman said:

"Everybody knew me… I wouldn't want to spread it [the abuse] around." (Older woman, IPA)

For those dependent on family members for care—including in cases where the perpetrator was also a caregiver—the risks of disclosure were perceived as even greater:

"In a way, I had to weigh it up. If I told somebody and he [perpetrator] found out, what's he going to do to me? He's going to hurt me even more. So, I didn't feel I could tell anybody."

(Older female, IPA)

Whilst practitioners operate within the confines of confidentiality procedures, older adults were not always aware of this. When confidentiality protocols were explained clearly and consistently however, participants described feeling reassured and more willing to disclose:

"I know when I talk to you [domestic abuse worker] that it doesn't go any further."

(Older female, IPA)

These accounts demonstrate how context, location, and relationships intersect in shaping whether an environment feels safe for disclosure. The findings highlight the need for clear and consistent explanations of confidentiality protocols, including any limits, at the outset of engagement to build trust.

The Right Person

Many older victim-survivors described uncertainties about whether particular professionals— especially within healthcare—were 'the right people' to disclose to. Healthcare settings were often perceived as inappropriate contexts for disclosure, with abuse seen as outside the remit of health professionals. Even when contact with health staff was frequent, this uncertainty often silenced disclosure. For example, one older male participant had weekly visits from community nurses and was asked if he had considered disclosing the abuse to them:

"They [health practitioners] won't be concerned about me and what goes on around here... they wouldn't be burdened with this... and I wouldn't want to trouble them." (Older male, AFA)

Participants were acutely aware of the time pressures faced by healthcare professionals, which reinforced their reluctance to share experiences of abuse. For some, this hesitancy was shaped by generational attitudes towards authority, where professionals were not expected to inquire into "private" family matters. In this context, whether someone was perceived as "the right person" to disclose to was bound up not only with role expectations but also with trust, cultural norms, and the relational conditions created during interactions:

"It's just embarrassing... I don't think I'd go to the dentist and tell him my partner has knocked my teeth out. I don't think I would tell the dentist. Sort of - if we'd got a rapport, maybe you'd feel that you could." (Older male, IPA)

This finding suggests that services must address older victim-survivors' uncertainty about "the right person" to disclose to by ensuring that professionals across different settings are equipped to respond appropriately. This requires communicating clearly to older victim-survivors that all staff have a responsibility to listen and respond to concerns about abuse, thereby reducing uncertainty about who is an appropriate recipient of disclosure.

For older victim-survivors, feeling that they had found "the right person" was often the decisive factor in whether disclosure occurred at all. Ensuring that professionals across sectors are prepared, approachable, and explicitly positioned as safe points of contact is therefore essential.

Professional Curiosity and Language

When professionals took the initiative to ask questions and show curiosity about possible abuse, participants said this created a space in which disclosure felt possible. Being asked directly about abuse conveyed that the professional recognised domestic abuse as part of their role, and participants described how empathy and attentive listening gave them confidence to continue engaging:

"I wanted someone to ask me, and if they had asked me, I would have told them." (Older female, IPA)

Participants emphasised that the language used by practitioners could act as either an enabler or a barrier to disclosure. Several explained that if they had been asked directly whether they were experiencing "domestic abuse," they would have denied it:

"If asked if I was experiencing domestic abuse, I would have said no." (Older female, AFA)

Many older people across the wider sample did not initially identify their experiences with the terminology of domestic abuse. Instead, they suggested that more exploratory or descriptive questions would have encouraged disclosure. For example, some indicated they would have responded affirmatively if asked whether they were having "difficulties at home," but not if asked whether they were "having problems." These subtle linguistic distinctions carried significant weight, reflecting generational differences in how experiences were named, understood, and spoken about.

At later stages of support, participants described becoming more comfortable with their experiences being framed explicitly as domestic abuse. However, they emphasised that initial engagement required language that was flexible, non-threatening, and responsive to their ways of describing lived realities. This gradual shift in comfort highlights the importance of meeting older victim-survivors "where they are" in terms of language, while carefully scaffolding understanding of domestic abuse over time.

Confidence Building and Facilitating Disclosures

Older victim-survivors highlighted the need for services to support disclosure as an incremental, relational process rather than a single event. Disclosure was described as unfolding over time, shaped by the gradual accumulation of trust and confidence:

"As time goes on, you part with more information. You build enough confidence to share even more." (Older female, IPA)

This confidence was not attributed to an inherent trait, but something that was actively nurtured through supportive interactions, recognition, and the assurance that disclosures would be heard without judgment and remain confidential within the organisational setting. In the context of ageing, the temporal dimension of disclosure is especially significant. Many older victim-survivors carried decades of victimisation, with abuse deeply embedded in family and community networks.

Generational norms around privacy, loyalty to family, and the historical silencing of domestic abuse further shaped their willingness to disclose. Building confidence to speak about abuse required trust, patient engagement, and culturally sensitive practice attuned to these dynamics. This reflects trauma-informed understandings of safety, which emphasise relational continuity and predictability as essential for enabling victim-survivors to disclose sensitive experiences (Sweeney et al., 2016).

The experience of first disclosure influenced further help-seeking at later stages. When met with positive responses, including belief and understanding, participants said they were more likely to disclose further at later stages, whilst negative or dismissive encounters led them to withdraw. Participants expressed particular frustration with formalised risk assessment tools, such as the Domestic Abuse Stalking and Harassment Risk Indicator Checklist (DASH RIC). These tools were frequently experienced as impersonal "tick-box" exercises, with their purpose rarely explained:

"I would disclose to people, but they only hear what they want to for a tick box" (Older female, AFA)

Some older victim-survivors believed these tools were designed to assess the perpetrator's needs rather than their own safety, leaving them feeling invisible within the process. This sense that practitioners were more concerned with the perpetrator than with their experiences undermined trust, particularly when layered with the anxieties many older adults already felt about navigating unfamiliar bureaucratic systems. This finding emphasises the need for assessments to be explained transparently, framed as tools to enhance victim-survivor safety, and embedded within ongoing relational engagement rather than treated as one-off information gathering exercises.

A Non-Judgemental Space to be Listened to and Believed

Participants consistently emphasised the importance of being able to disclose at their own pace, without pressure, prescriptive advice, or implicit criticism of their choices. They valued professionals who demonstrated acceptance and belief, combining sensitivity with practical guidance:

“I felt that they would judge me, but I went to the police, and they were brilliant with me... He believed me. And that was the first time I’d told anybody [about the abuse] and he believed me.”

(Older female, IPA)

For many, generational expectations heightened the weight of perceived criticism. Having been socialised to endure hardship or to keep family matters private, older participants described disclosure as an act requiring significant courage. In this context, even subtle signals of doubt could deter further sharing, while patience, respect, and validation were described as vital in establishing safe professional relationships:

“I think they’ve got to listen, they’ve got to accept what the person says without sort of thinking, oh, she’s lying or whatever... It is very, very difficult for somebody like me to say something.” (Older female, IPA)

More than any other factor, participants stressed the importance of being listened to and believed when discussing painful and stigmatised experiences. Professionals who dismissed or questioned their accounts undermined their sense of safety and reinforced long-standing barriers to disclosure.

Advocacy

“I wanted someone to advocate for my needs.” (Older male, IPA)

Advocates were described as particularly important, not only for navigating complex systems but also for continuity of contact. This continuity enabled trust to build gradually, which participants contrasted with the rushed, formal style of time-limited appointments. Informal settings such as coffee mornings or community activity groups were described as especially conducive to disclosure—spaces where older adults could talk more freely, away from the pressures of clinical environments:

“I’d sort of try to get them [victim-survivors] on their own and ask, ‘Would you like to come out for a coffee?’”

(Older female, AFA)

In this sense, advocacy functioned not only as a form of practical support but as part of the iterative process of help-seeking, where relational continuity and informal environments offered safer conditions for disclosure to unfold over time (Compton et al., 1989; Anderson and Saunders, 2003).

Good Practice Case Study – Professional Safe Spaces and Support

Live Fear Free Helpline is the Wales-wide 24-hour helpline, offering free confidential support around domestic abuse, sexual violence or violence against women. The helpline offers support via telephone, text, live chat and email.

Margaret, aged over 70 years – Support through Live Fear Free Helpline

The Live Fear Free Helpline has seen an increase in calls from older victim-survivors who have additional needs related to age that present barriers to navigating the services which are designed to support them. Increasingly Helpline practitioners are providing additional ongoing support for older callers to advocate for their needs and help them access services.

Margaret, a woman in her late 70s, called the Helpline following a physical and verbal assault by her husband. Margaret said that she had called the Helpline because she was “at the end of her tether”. The helpline practitioner checked with Margaret on her immediate safety at the time of the call and checked that she could talk freely without fear of being overheard by her husband. Margaret disclosed that she had had suicidal thoughts and that the previous evening she had attempted to take her own life. Her husband was aware of this but had not sought help for her.

Margaret told the Helpline practitioner that she had multiple health needs and poor mobility, and that her husband was her primary carer. This had compounded Margaret’s reluctance to seek help, as she believed her husband’s claims that her care and support would be withdrawn if she talked to anyone about the abuse. Margaret was fearful of the intervention of statutory organisations, especially the police and social services, and this mindset had been perpetuated by her husband.

The Helpline practitioner discussed the case with the Helpline Safeguarding Lead, who agreed that Margaret met the criteria of an ‘adult at risk’ as outlined in the ‘All Wales Safeguarding Procedures’ and that a concern should be raised with the Local Authority Safeguarding Adults Team. The initial response from the Local Authority was that the concern would not be progressed. The reasons cited were that Margaret was not identified as suffering from neglect and had displayed that she had capacity to safeguard herself through her call to the Helpline.

The Helpline Safeguarding Lead contacted the Local Authority challenging the decision and they agreed to review the case. Within an hour the Helpline received a call from the Local Authority to confirm that they would progress the concern and that a Safeguarding Officer would visit Margaret later the same day and she would be offered support.

This case demonstrates good practice by the Live Fear Free Helpline in providing Margaret - an older victim-survivors with complex health needs - with a safe and confidential space to talk openly about the abuse she was experiencing. The practitioner listened empathetically, recognised the additional vulnerabilities that come with older age and poor mobility, and ensured that Margaret felt heard and supported as a victim-survivor of domestic abuse. By advocating on Margaret’s behalf and challenging the Local Authority’s initial decision not to progress the safeguarding concern, the Helpline ensured that her voice was central to the process and that her specific needs as an older victim-survivor were recognised. This proactive, trauma-informed approach enabled Margaret to access the safeguarding and support she required, protecting her safety and reinforcing her right to live free from abuse.

Summary

Older victim-survivors stressed that disclosure of abuse depended less on the physical service environment and more on trust, confidentiality, and the quality of professional interactions. Opportunities for private conversations, clear explanations of confidentiality, and sensitive, non-judgemental responses were critical in enabling disclosure. Many participants were uncertain about who was “the right person” to tell, highlighting the importance of professional curiosity and language that feels accessible. Disclosure was described as an incremental process built over time through continuity, empathy, and advocacy, with informal community-based settings often providing safer spaces than formal appointments. These findings underline the need for flexible, relational, and trauma-informed approaches that support older people to disclose abuse at their own pace.

The ways in which professionals create safe spaces and signal their readiness to respond to domestic abuse are closely tied to how services initiate and maintain contact with older victim-survivors. Having opportunities to disclose abuse is only the first step, the nature, timing, and method of subsequent communication can determine whether victim-survivors feel able to engage with available support. The next section will discuss contact preferences and support needs.

06

Contact Preferences and Support Needs

This theme explores older victim-survivors' preferences for how services should initiate and maintain contact, drawing on the experiences of nine participants and supported by insights from the wider Dewis Choice sample. Participants reflected on the types of communication they found most helpful, the importance of timing and privacy, and the challenges of navigating multiagency involvement. Their accounts highlight how seemingly minor adjustments in communication practice—such as proactive outreach, clear introductions, and flexibility in method—can significantly affect engagement.

Proactive Contact

Eight of the nine participants stated that they wanted professionals to contact them to initiate support following initial referrals to specialist domestic abuse organisations, in preference to having to make initial contact themselves. This preference was shaped by anxiety, uncertainty about what services could offer, and self-doubt over whether their experiences "counted" as domestic abuse. As one woman explained:

"If you hadn't rung me, I don't think I would have reached out."

(Older female, IPA)

Without proactive outreach, participants reported they might have withdrawn, doubted their own perceptions of the abuse, or assumed that no help was available for older adults. Proactive contact was therefore experienced as validating, reassuring, and a signal that their situation was taken seriously.

Telephone vs Face-to-Face Contact

There was variation in preference for telephone or face-to-face support across the nine interviews and the wider sample. Some older victim-survivors preferred initial contact to be made by telephone, as they described the telephone provided a less intimidating first step before progressing to in-person meetings:

"I was too nervous at first, so phone calls were perfect, but when I was ready and strong enough, I was glad we met."

(Older female, AFA)

Telephone contact was valued for its immediacy and accessibility, particularly in the early stages of support. Participants appreciated being able to speak to a practitioner when feeling anxious, without waiting for a scheduled visit:

"You don't have to wait for a visit, it's immediate." (Older female, IPA)

Some older victim-survivors described experiencing heightened levels of fear after initial disclosure, as they were anxious that professionals might phone them unexpectedly while the perpetrator was in the home:

"If he [the perpetrator] was in the house, I wouldn't have been able to talk." (Older female, IPA)

These accounts highlight the need for careful planning and agreed timing of communication methods, particularly in situations where the perpetrator remains in the home. Several older victim-survivors emphasised the importance of face-to-face contact when accessing support. For some, this was a matter of preference, for others, it was a necessity. In cases where hearing or speech impairments made telephone communication impractical, inperson provision was the only viable option.

Ensuring that communication needs were identified at the onset of interactions was a key concern. For example, one participant reported that he was hard of hearing. During a face-to-face interaction with a professional he described repeatedly asking the professional to talk louder. He was not asked if he had a hearing difficulty or offered the opportunity to have a conversation in an environment with less background noise:

It took me a couple of times saying, "Sorry, what was that?" I couldn't hear... Nobody even asked me at all [if I was struggling with my hearing] ... I definitely felt as if I was missing out on important things." (Older male, IPA)

Accessibility challenges also extended to the physical environment and organisation of services. Across the wider sample, older victim-survivors with conditions affecting physical mobility commented that the location of services was problematic. Buildings labelled as “accessible” were sometimes difficult to reach without private or adapted transport, creating further barriers for those with limited mobility. Participants also reported that professionals did not always take account of sensory impairments, which restricted their ability to engage fully in conversations or appointments. These findings highlight the need for outreach-based approaches and flexible models of service delivery that are responsive to older people’s diverse mobility, sensory and communication needs.

Simplifying Support: One Point of Contact

Participants cited the value of having a single point of contact with an independent advocate to support them in navigating multiagency responses regarding the domestic abuse. Some described feeling confused and overwhelmed by an influx of calls from unknown professionals, which led to them withdrawing and, in some cases, disengaging:

“I had phone calls from people I didn’t know, I didn’t know who they were, what they were doing, or what they represented. It just became very confusing.”

(Older male, AFA)

For older victim-survivors, this confusion was compounded by the broader context of ageing. Many were already receiving numerous calls related to healthcare and other statutory services, making it harder to distinguish between routine health contact and responses to domestic abuse.The cumulative effect was a blurring of roles, where professionals felt interchangeable and trust was difficult to establish. Age-related factors such as memory loss, hearing difficulties, or cognitive decline further intensified the strain of processing multiple calls from unfamiliar professionals.

A single point of contact was therefore valued not only for its efficiency but also as an age-appropriate adjustment that reduced

the cognitive and emotional load of retelling their story. Crucially, it offered continuity and familiarity—conditions that fostered trust over time. In this sense, a single trusted contact functioned as a relational safe space, providing stability and recognition in contrast to the fragmented, transactional nature of multiple professional interactions.

Whilst the older victim-survivors recognised that in some circumstances more than one professional may need to contact them, the participants emphasised the value of the professional being obvious at the start of the conversation who they were, what agency they were from and the reason for making contact.

Emergency Situations

Participants were not aware that they could contact 999 in emergencies. There were some high-risk situations that the older people described, which they did not believe warranted police support. This highlighted the need for practitioners to reassure older victim-survivors that they can, and should, call 999 if they are at risk.

Good Practice Case Study - Contact Preferences (a Single Point of Contact)

Age Cymru is the largest charity dedicated to supporting older people in Wales. It provides a range of services, including free confidential advice and advocacy, and campaigns for older people’s rights.

Alice, aged 78 years
– Support through Live Fear Free Helpline

Alice was referred to Age Cymru by another third sector organisation due to concerns over coercive and controlling behaviour by adult family members. Alice has dementia and short-term memory issues. The Age Cymru Advocate visited Alice on numerous occasions to establish her wishes and views and kept detailed records which helped Alice to recall the conversations.

The Advocate had been supporting Alice with updating her Will since 2024 as Alice no longer felt the Will met her wishes. Due to her diagnosis of dementia, the process has ensured that

Alice's wishes and feelings have been consistent and captured over a period of time. However, on the last two visits by the Advocate, Alice's grandson has been present and the instructions about the Will had substantially changed. Alice's solicitor, who was present at several of the visits, and the Advocate shared concerns that there is coercive and controlling behaviour by adult family members with a vested interest in Alice's Will. There were additional concerns as the family had applied to be appointed as attorneys (Lasting Power of Attorney - LPA) for Alice for both health and financial decisions. It transpired that Alice's grandson also had control of her bank account even though the LPA had not been finalised.

On one of the Advocates visits to support Alice with finalising her Will, during the appointed solicitor's home visit, Alice's grandson was also present. During this visit, Alice's grandson produced a typed document, which he claimed Alice had signed during his visit the day before. The piece of paper stated very different wishes to those that Alice had consistently told to the Advocate. Despite Alice's mental capacity being questioned by her grandson, both the Advocate and the Solicitor agreed Alice had capacity to make her Will the way she wanted it.

Alice's grandson said that it was the right of the family that Alice should leave everything to them in the way it was outlined in the document. The Solicitor insisted she wanted to speak to Alice without her grandson being present to ensure Alice had a protected space to discuss her wishes. Since her grandson's involvement the instructions about Alice's Will have changed beyond reasonable parameters. Alice was clear in her ongoing discussions with the Advocate and her Solicitor that she didn't want her Will revised in the way her grandson had presented it.

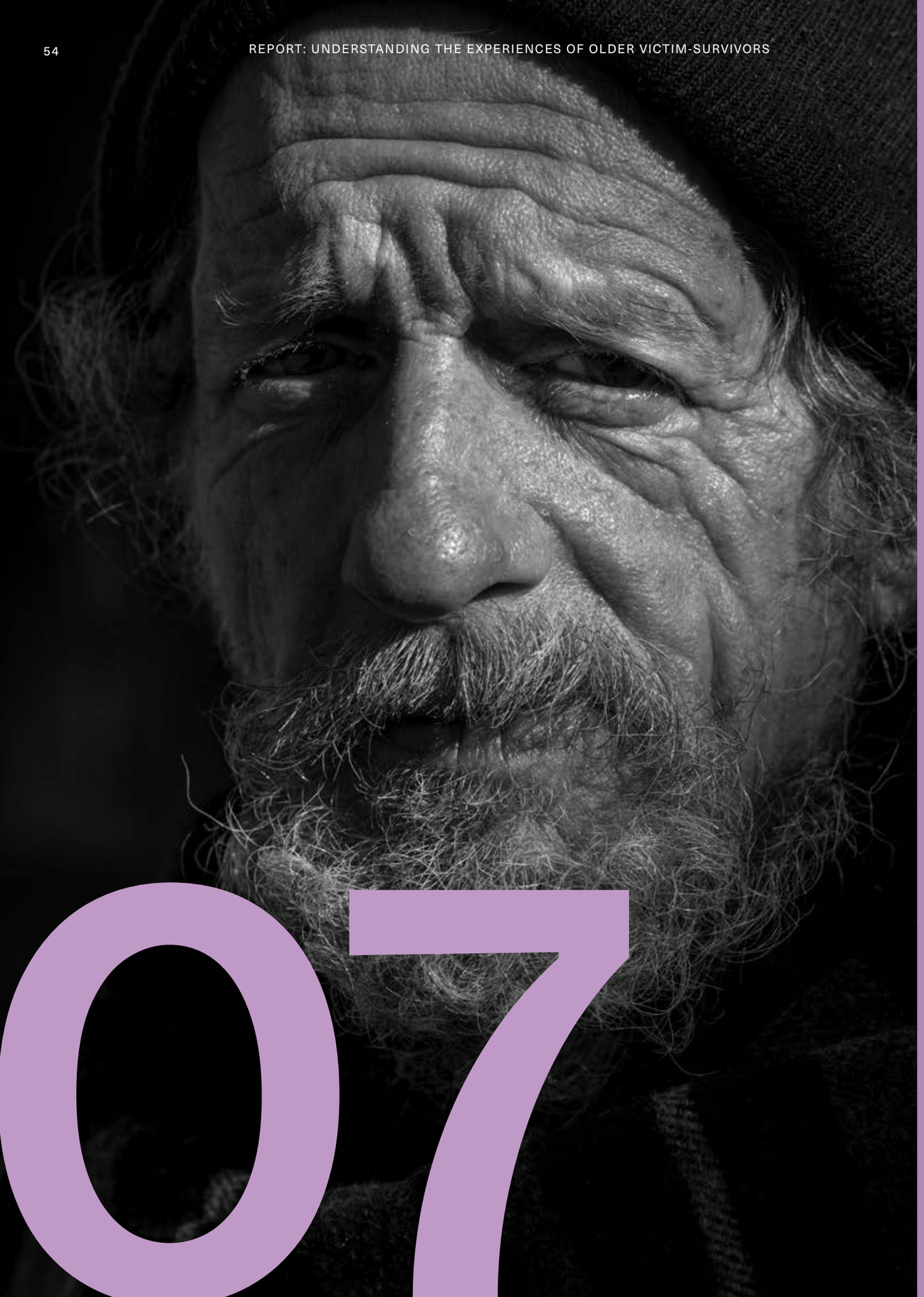
The Advocate and the Solicitor discussed making a referral to the Local Authority Adult Safeguarding team to raise concerns. The safeguarding process was discussed with Alice, who agreed to the referral being made. The Solicitor also explained to Alice's grandson that from now on the arrangements with Alice about her Will and the contents of the Will would be confidential and would be held by the Solicitor.

The Local Authority Safeguarding Team held a multi-agency strategy meeting where it was agreed that the Advocate would remain involved as she has a relationship of trust with Alice. This case study demonstrates good practice through the coordinated, person-centred response of the Advocate, Solicitor, and Safeguarding team. The Advocate built a trusting relationship with Alice over time, ensuring her views were consistently recorded and respected, even amidst external pressures. The Solicitor upheld Alice's legal rights by recognising her mental capacity and insisting on private conversations to ensure her voice was not influenced. Both professionals demonstrated vigilance and ethical responsibility by recognising the signs of coercion and initiating a safeguarding referral with Alice's informed consent. The Safeguarding Team acted appropriately by convening a multi-agency strategy meeting, ensuring ongoing support and protection for Alice through continued advocacy involvement. This collaborative approach placed Alice's autonomy and well-being at the centre of all decisions.

Summary

Older victim-survivors expressed a preference for proactive, personalised contact that balanced sensitivity with clear, practical guidance. Telephone contact was appreciated for its immediacy but needed to be carefully timed to ensure safety. Flexibility—offering both telephone and face-to-face contact—was key to meeting varied needs. A single point of contact helped survivors navigate complex systems and reduced the risk of disengagement.

Importantly, service design and delivery must consider the structural and practical barriers that shape older adults' engagement, from transport and mobility constraints to sensory impairments and lack of accessible information. By combining proactive outreach, flexible communication methods, and coordinated case management, services can create conditions in which older victim-survivors are more likely to engage, sustain contact, and access the full range of support available to them. The way services initiate and maintain contact is only one part of the equation; equally important is what happens after that first conversation. Once disclosure has occurred, the kind of support offered—and how it is delivered—can determine whether older victim-survivors feel heard, understood, and empowered to engage with help. The next theme examines the priorities older victim-survivors identified for service provision, encompassing the emotional, informational, and practical forms of support they consider most valuable.



07

Older Victim-Survivors' Priorities from Service Providers

This section examines what older victim-survivors consider most important when engaging with services, focusing on the forms of support that foster trust, understanding, and safety. Drawing on the accounts of nine participants and the wider Dewis Choice sample, the findings show a clear preference for sustained, person-centred support that addresses both immediate safety and longer-term recovery. They highlight how emotional, informational, and practical assistance intersect, creating environments in which older adults feel heard, valued, and better able to move forward.

Choice, Control and Managing Expectations

For many participants, engaging with services carried the risk of losing control. Statutory involvement was often associated with decisions being taken out of their hands, compounding the disempowerment already experienced within abusive relationships. These fears were eased when professionals adopted a collaborative approach—explaining available options, providing accurate information about rights and entitlements, and encouraging informed decision-making:

“The issue is I don’t know what I want help with until you tell me what’s available. I don’t always know what I want or what I am entitled to until you tell me.”

(Older female, AFA)

When informed choices were given, older victim-survivors reported feeling respected and more able to take steps at their own pace. Equally important was the need for professionals to manage expectations transparently at the point of disclosure. Participants wanted clarity about how their information would be used, what actions would follow, and what support would remain available. Without this reassurance, disclosure could feel unsafe, leaving them feeling anxious or abandoned:

“They’ve just got to say, ‘we believe you, and this is how we can help you’…I’ve given out all that information and at the end of it, they just walk out the door and they’ve raised all my fears up again. And it is really difficult to get back to where you were before you said anything.” (Older female, IPA)

Participants reflected on their readiness to engage with civil and criminal justice processes, calling for practitioners to revisit options over time and explain roles, procedures and potential outcomes with honesty. Clear and realistic guidance—particularly when considering legal pathways—helped to prevent re-traumatisation when outcomes did not meet expectations.

Across the wider sample, many recounted experiences where service providers promised action but failed to follow through. This inconsistency not only undermined trust but reinforced feelings of exclusion, leaving some older victim-survivors feeling invisible within systems designed to protect others:

“They took all the notes, but didn’t actually do anything for me… It’s just that it seems to be no room for people like me.”

(Older female, AFA)

Trust was strongest when practitioners were upfront about what could and could not be achieved, avoiding false reassurance or unfulfilled promises.

Helping Victim-Survivors Make Sense of Their Experiences

Many participants described how, in the initial stages of disclosure, they struggled to identify their experiences as domestic abuse. They lacked the language and knowledge to articulate what was happening and relied on professionals to help them make sense of their situation. Support that framed abuse as the responsibility of the perpetrator, rather than the victim-survivor, was described as transformative and, at times, life-saving:

"I made two feeble attempts at committing suicide actually, before I got put in touch with [organisation name] and they actually guided me through things. Helped me considerably and I think if it wasn't for them, I don't know where the hell I'd be now, I really don't." {Older male, IPA)

This process not only alleviated self-blame but also helped participants recognise their experiences as part of a wider pattern of abuse.

Empathy and its Complexities

Empathy was described as the foundation of trust. Older victim-survivors valued professionals who listened without judgment, validated their accounts, and treated their disclosures with dignity. Yet empathy was not always experienced equally. Some older women observed that practitioners appeared to extend more sympathy towards male perpetrators—particularly those who presented as frail or in need of care—than to them.
These responses echoed perpetrators' own assertions that victim-survivors would not be believed:

"He [the perpetrator] told me they wouldn't want to know me."

(Older female, IPA)

This finding highlights the need for professionals to be conscious of how perceptions of perpetrator vulnerability may inadvertently undermine a victim-survivor's credibility and reinforce marginalisation.

Practical Assistance

Participants expressed a need for practical assistance to support them with accessing basic entitlements like food, clothing, finances and housing. Older victim-survivors commented on how they had difficulty navigating systems, for example, filling in forms, accessing services online, and making phone calls to services. Some older victim-survivors reported being told by services that they were not eligible for resources and being unaware that they could challenge decisions or lacked the confidence to do so. For example, older victim-survivors had not identified themselves as victim-survivors of domestic abuse on housing applications, which meant they had not been given priority status for housing:

"I've always been an independent person... I would have soldiered on." (Older female, AFA)

The need for a single point of contact was repeated, along with the need for consistent longterm support and advocacy for older victim-survivors to ensure they had equitable access to basic rights and entitlements.

Linking in with Community Services

Beyond immediate safety, older victim-survivors spoke of the challenge of rebuilding lives marked by loneliness and disconnection. They emphasised the value of community-based services that offered opportunities to reconnect socially, make new friendships, and create meaning in the aftermath of abuse. For some, this was described as the most difficult stage of recovery:

“I’ve got to try and build a life but I’m lonely. You know, I really am lonely. I’ve got to build my life somehow now and I’m not quite sure I’m going to do that.”

(Older female, IPA).

These accounts illustrate that effective support for older victim-survivors must extend beyond immediate crisis response to include longer-term pathways to social belonging, recovery, and independence.

Good Practice Case Study – Older Victim-survivors Priorities from Service Providers

West Wales Domestic Abuse Service is an independent specialist domestic abuse charity which provides an integrated and holistic service, addressing the needs of survivors and their children from the point of crisis through recovery and onto independent lives. The service includes a specialist project supporting older victim-survivors of domestic abuse.

Gwen, aged 86 years – Support through West Wales Domestic Abuse Service Specialist Older Persons Worker

Gwen was referred by social services for support with West Wales Domestic Abuse Service (WWDAS) in April 2024. She was first identified as a victim of domestic abuse in 2023 by statutory bodies following several safeguarding adult referrals. Gwen went to a care home in June 2023; however, it was 11 months from this point before Gwen was referred to WWDAS for support.

Prior to moving to the care home, Gwen’s home was attended three times by police. On each occasion, she asked to be taken somewhere safe but remained at home. Gwen later explained that her husband would listen at the door during these visits, which made it difficult for her to speak freely. When she first called for help, it took some time—around three weeks—for officers to attend, and Gwen struggled to articulate the severity of her situation, only managing to say that her husband “was not being nice.” She reflected that she “didn’t know how to express the awfulness of what was happening” and felt invisible and frightened, especially as her reduced mobility meant she couldn’t simply leave the situation on her own.

The WWDAS support worker made a joint visit with a social worker to meet Gwen in the care home where she disclosed economic abuse, sexual violence, coercive and controlling behaviour. When asked if she had previously disclosed this, Gwen said that she had not, as she had never been asked before. Gwen explained further that she didn’t feel comfortable to disclose the sexual abuse to the male police officers who had previously attended her home address.

Married for over 40 years, Gwen explained that her husband was always coercive and liked to have his own way. In later years he became more abusive when Gwen’s mobility became reduced, and he began to drink more. She said that he expected her to do all the housework, even when she returned home following a hysterectomy. Gwen disclosed that her husband would often leave her alone at home for days at a time and that he would purchase food that was

unsuitable for her dietary needs as a diabetic, which could be life threatening. Gwen also reported that her husband refused items that she needed to support mobility including refusing to get the stair lift repaired, which forced her to remain upstairs and unable to access the downstairs of the house.

After building trust with the WWDAS support worker, Gwen began to fully disclose the extent of the sexual violence she had experienced from her husband, including being forced to have sex when she felt unwell following surgery. The support worker explored issues around consent to sexual activity with Gwen and Gwen confirmed that the sex was not consensual, but she had not disclosed this to the police or anyone else. When asked why, Gwen said that she didn't feel comfortable disclosing it to the police and that no-one else had asked her about sexual abuse.

With Gwen's consent the WWDAS worker made a referral for specialist sexual violence support. Gwen also agreed for a Police Domestic Abuse Officer (DAO) to visit her to discuss the offences that had been committed against her. WWDAS worked closely with the sexual violence service to support Gwen to engage in a forensic interview regarding the marital rape.

Gwen was supported by the WWDAS worker to move from the care home into supported living accommodation, helping her to purchase furniture and ensuring she had essentials, for example, a kettle and bedding. Gwen was also supported to access a solicitor to help her recover personal belongings of financial and emotional value from her marital home.

The specialist older persons support worker at WWDAS created a safe and trusting environment where Gwen finally felt heard. Gwen shared that previous professionals made her feel invisible, but the collaborative, person-centred approach gave her the confidence to disclose the full extent of the abuse and to believe that her husband could be held accountable. She expressed that without intervention she feared her husband intended for her to die in her home, and due to her mobility issues, she could not leave on her own.

With coordinated support from WWDAS, specialist sexual violence services, and social care, Gwen was able to achieve safety, secure legal advice, and reach a divorce settlement. She has since begun planning a move closer to family and expressed feeling empowered, informed, and supported. Her feedback reflected the impact of this joint, trauma-informed response: "I can now look forward to a future." This case demonstrates how safe, specialist support, combined with effective multi-agency working, can empower older survivors to find their voice, access justice, and begin recovery.

Summary

Older victim-survivors emphasised the importance of services that went beyond short-term interventions, offering sustained, person-centred support. Central to their accounts was the need for control and choice in decision-making, alongside clear and realistic information to manage expectations. Many relied on professionals to help them recognise and make sense of abuse, shifting responsibility away from themselves and onto perpetrators. Empathy and validation were described as the foundation of trust, though some noted that professionals' sympathy was sometimes directed more towards perpetrators than victims. Practical assistance with housing, finances and navigating complex systems was highlighted as essential, as was advocacy and continuity of support. Finally, participants stressed the value of community-based opportunities to reduce loneliness and rebuild meaningful lives after abuse.

Together, these findings underline the need for relational, flexible and sustained approaches that enable older people to feel safe, respected and supported in recovery.

08

Addressing Trauma Across the Life Course

Experiences of trauma across the life course often intensify in later life. For many older adults, retirement, bereavement, or increased isolation can prompt reflection on past abuse, sometimes bringing suppressed memories and unprocessed trauma to the surface. Research on older victim-survivors of sexual violence and domestic abuse highlights that help-seeking is often a long, complex, and fragmented journey shaped by personal, societal, and systemic barriers, underscoring the urgency of developing coordinated, specialist provision (Zerk, Freeman and Roberts, 2024).

Good Practice Case Studies – Addressing Trauma Across the Life Course

New Pathways is the largest sexual violence support provider in Wales, with 30 years experience of delivering specialist therapeutic support to adults and children affected by the trauma of rape, sexual assault or sexual abuse. As a charitable organisation, New Pathways offer a full range of free specialist crises, advocacy, wellbeing and counselling services.

Female, aged 62 years – Support through New Pathways Independent Sexual Violence Adviser (ISVA)

The client, a 62-year-old female, was referred for ISVA support by the police. She had recently retired and has a husband and one adult child.

In early 2022, the client suffered a mental health breakdown as she was struggling to cope with the trauma that she experienced as a child. She had recently retired and described that having too much time on her hands had caused her to reflect on past issues, which resulted in her having flashbacks for issues that she had never spoken about, and that she thought were in the past. This prompted her to disclose to her family that she had been sexually abused by her stepfather when she was a child. The client had carried this burden alone for more than fifty years, and she said that she felt a deep sense of relief to finally tell someone. It was only when the client told her family, that her brother disclosed that he too had been a victim of sexual abuse by the stepfather. This prompted both siblings to come forward and make an initial report to the police.

The client found the reporting process extremely difficult, but she felt supported and believed by the police. However, she was still struggling to cope with the trauma and felt constantly anxious. She therefore agreed to be referred into the ISVA service at New Pathways.

During the initial assessment meeting, the ISVA supported the client to ensure that she was aware of her rights and the options available to her. The ISVA also helped the client to understand the criminal justice process so that she could make informed decisions about what she wanted to do. Having considered her options, the client decided to proceed with her report to the police and was subsequently supported by the ISVA during the police interview process.

During the investigation process the ISVA acted as the central point of contact for the client with the police, Crown Prosecution Service (CPS) and other agencies. This enabled the ISVA to keep in regular contact with the client to update her regarding the progress of the investigation.

In addition, the ISVA worked with the client on positive coping strategies and stabilisation techniques, which the client found extremely useful and helped her to manage intrusive thoughts and flashbacks.

The investigation process, through to CPS decision took 14 months. The client found the duration of time that she was waiting for a CPS decision to be difficult. Not knowing what the outcome would be, left her feeling in limbo, and she reported feeling grateful for the support from her ISVA, which she said was key to keeping her in the criminal justice process.

Following a charging decision by the police, the alleged perpetrator pleaded not guilty to all charges relating to client and her brother and a trial was set for seven months later. While awaiting the trial, the ISVA supported the client throughout court preparation and arranged for the client to attend a pre-trial visit to the court so that she could familiarise herself with the layout. This helped to alleviate some anxieties that the client had around giving her evidence in the courtroom. The ISVA also applied for special measures for the client, which enabled her to give her evidence behind a screen in the courtroom. Again, the client found this extremely helpful.

After giving her evidence in court, the client said that she felt empowered and proud that she had the opportunity to have her voice heard in the court arena. She added that she could not have done it without the support of her ISVA.

This case demonstrates New Pathways' commitment to delivering trauma-informed, client-centred support throughout the criminal justice process. The ISVA consistently upheld best practice by ensuring the client was informed, empowered, and emotionally supported at every stage of her journey. The practitioner showed sensitivity to the client's experiences as an older woman, recognising how retirement and her life stage had triggered the resurfacing of trauma, and tailored support accordingly. The ISVA provided age-appropriate, compassionate care that acknowledged the client's lifetime of silence and helped her navigate the process with dignity and confidence. By acting as a reliable point of contact and offering both emotional and practical support, including court familiarisation visits and special measures applications, the ISVA helped the client feel safe and in control. The continuity of care and responsiveness to the client's evolving needs exemplify good practice in supporting older victim-survivors of historic sexual abuse and the complex and emotionally challenging legal processes.

Male, aged 65 years – Support through New Pathways Counselling Service

A 65-year-old male self-referred to New Pathways in December 2024, with a second referral being made by a charitable organisation. The client was offered a first assessment and precounselling support within two weeks, before starting in counselling in March 2025.

The client contacted New Pathways in relation to the ongoing impact of sexual abuse by an uncle which he had suffered during childhood. The abuse had been reported to the police and the perpetrator had received an eight-year custodial sentence in 1974, but the client stated that he had never received any support at the time or since, and that his family regarded it as a "shameful secret" and consequently had never spoke about it again.

In the first session the client spoke of his religious beliefs and not feeling "good enough" when trying to follow his faith to inform his path in life. The client also expressed the need to be heard, and the counsellor encouraged him to express his thoughts and feelings, and to share memories in a safe space. The client's goals were to understand his feelings and to stop feeling anxious and depressed. He also wanted to stop using alcohol as a way of coping.

To reinforce the client's sense of self and self-healing-process the counsellor focused on the core concepts of Person-Centred Counselling. The client described his way of coping as "blocking and detaching" from memories, which often involved the use of alcohol. To work with this the counsellor focused on the "why" of therapy for the client, helping him to develop positive coping strategies and encouraging him to use the safety of the therapeutic space to explore his thoughts and feelings. In this the client spoke of deep traumatic memories and his profound sense of shame and guilt for the impact that his abuse had had on the family. Within the processing of internalised trauma, the client was able to verbalise his pain, whilst at the same time expressing the power and affirmation of being heard.

The client, for first time acknowledged that not all his pain came from sexual abuse. The client described that having the time to reflect gave him the "opportunity and permission" to also recognise the impact of the emotional and physical abuse that he had experienced from his mother within the home. As the counsellor explored this with the client, he spoke of a "light bulb moment" expressing that as a child he had blamed himself for

the impact of the abuse, but in doing so he had dismissed and suppressed the fact that his mother also blamed him, because it was too painful a truth to contemplate. This had subconsciously kept him "stuck" for many years and left him not able to move forward. In his words, "now it all makes sense".

The client stated in the initial session that he did not know if he would continue as he "doubted that it would it work for him". However, some weeks later when giving some feedback during a review session the client said that he had "wasted so many years blaming myself for something that was not mine to own" and that he wishes that "I had done this far sooner."

The client has made great progress towards achieving the goals that he set for himself and feels that he has the confidence and skills that he needs to move forward with his life with a newfound optimism.

This case study highlights the vital importance of offering a safe and supportive therapeutic space for older clients processing abuse that occurred many years ago. The non-judgemental safe space enabled the client to speak openly about the abuse, break through feelings of shame, and recognise the broader emotional impact that persisted into later life.

09

Conclusion

This concluding section considers the wider implications of the study, highlighting how services, policies, and systems must adapt to meet the needs of older victim-survivors. Drawing on participants' accounts and the wider evidence base, the findings show that domestic abuse in later life is shaped by personal, social, and structural factors often overlooked by current models of support. They point to clear opportunities for practice and policy to move beyond age-neutral approaches, ensuring older adults are protected from harm and supported to rebuild safety, autonomy, and connection.

This study has highlighted the distinctive challenges that older victim-survivors of domestic abuse face, as well as the opportunities that exist for creating more inclusive and effective responses. The accounts shared by participants illustrate how domestic abuse in later life is frequently rendered invisible, both within wider social discourses of ageing and in the policies and practices of frontline services. Older adults often encounter barriers rooted in fear, stigma, and self-blame, compounded by structural issues such as inaccessible referral pathways, limited outreach, and a lack of age-appropriate provision. These factors silence disclosure and deepen isolation.

For practitioners, the findings emphasise the importance of relational practice. Disclosure does not occur in a single moment, but emerges gradually, fostered through trust, continuity, and respectful engagement. Professionals who take the time to listen without judgement, who ask direct but sensitive questions and explain confidentiality clearly are pivotal in creating the conditions in which older people feel safe to share their experiences. Empathy, consistency, and professional curiosity can transform interactions, enable disclosures and build the foundation for recovery. Even small acts of recognition—acknowledging a person's story, validating their feelings, or offering a steady point of contact—can carry profound weight in later life.

For policymakers and strategic leads, the study underscores the urgent need for systemic change. Current models of provision often mirror approaches designed for younger adults, overlooking the realities of ageing, disability, and social isolation. Policy frameworks must explicitly recognise domestic abuse in later life and invest in services that are flexible, accessible, and tailored to the needs of older adults. This includes embedding older people's experiences into awareness campaigns, ensuring risk assessment tools capture the specificities of abuse in later life, and prioritising service designs that reduce fragmentation through single points of contact and coordinated responses. Targeted outreach—through health, social care, housing, and community services—is essential to reach those who may never approach specialist organisations.

This study is limited by its small, non-representative sample of nine participants. Further research is needed to explore the diverse experiences of older people across different social, cultural and community contexts. For example, research indicates that older LGBTQ+ individuals may face fears of discrimination within mainstream services or invisibility in age-specific provision (Wydall et al., 2023), while survivors from racially minoritised communities may encounter linguistic barriers, mistrust of statutory agencies, or culturally specific forms of coercion (Izzidien, 2008). Without addressing these intersecting inequalities, safe space models risk reproducing exclusions rather than dismantling them. At the same time, policy and practice must ensure that older victim-survivors are not marginalised within domestic abuse responses but are placed at the centre of strategies designed to prevent harm and promote recovery in later life.

Older victim-survivors must no longer be treated as an afterthought within domestic abuse policy. Their perspectives must be integrated into service co-design, data collection, and training for professionals across sectors. In doing so, services can move beyond short-term crisis intervention to deliver sustained, person-centred support that recognises the long-term impacts of trauma and the importance of rebuilding social connection in later life.

Taken together, these findings call for a shift in both practice and policy: from reactive to proactive, from fragmented to coordinated, and from age-blind to age-inclusive. If organisations and practitioners are supported with the training, resources, and frameworks they need, safe spaces for older victim-survivors can become the norm rather than the exception. At its heart, this is not only about protecting older adults from harm, but also about affirming their dignity, amplifying their voices, and ensuring their right to live free from abuse in later life.

10

Recommendations for Organisations

This section outlines practical steps that organisations can take to strengthen their responses to domestic abuse in later life, focusing on the approaches that best support older victim-survivors and help create environments in which they feel safe, recognised, and able to access meaningful assistance. The findings highlight how organisational design, outreach, and service delivery must work together to reduce barriers, enhance trust, and ensure that older adults are offered clear pathways into help.

1. Develop Age-Inclusive Safe Space Initiatives

- Design physical, community, and digital safe spaces that are specifically tailored to older adults' needs, accounting for mobility, sensory impairments, and digital literacy.
- Ensure visibility of older victim-survivors in promotional materials, using inclusive language and imagery.
- Embed co-design with older adults as standard practice across commissioning processes.

2. Proactive and Targeted Outreach

- Fund and deliver awareness campaigns focused on older adults to counter the underrecognition of domestic abuse in later life.
- Partner with services accessed by older adults (e.g. pharmacies, libraries, GP surgeries, care services) to disseminate information and offer safe disclosure points.

3. Flexible and Accessible Service Models

- Commision outreach and community-based models that account for limited transport, mobility, and technology access.
- Ensure services are offered in environments familiar and comfortable for older people, such as community centres, warm space initiatives, day centres, libraries, or community cafés.

4. Single Point of Contact and Coordinated Care

- Assign or offer referral to dedicated advocates or caseworkers to reduce fragmentation and ensure consistent long-term support.
- Coordinate between agencies to prevent overwhelming older victim-survivors with multiple contacts and repeated assessments.
- Formalise single points of contact within multi-agency frameworks to reduce fragmentation.

5. Improved Referral Pathways

- Establish clear and visible referral systems that are age-sensitive, including pathways for older male victim-survivors who often face additional barriers.

6. Data Collection and Service Design

- Enhance data systems to better capture the prevalence and experiences of domestic abuse among older people, including those aged 75 and over.
- Involve older survivors in service co-design to ensure relevance and accessibility.
- Ensure that data informs commissioning decisions and service evaluation.

11

Recommendations for Practitioners / Professionals

This section outlines approaches that frontline practitioners can use to support older victim-survivors in ways that feel safe, respectful, and empowering. Drawing on participants' accounts, the recommendations highlight the behaviours and communication styles that make the greatest difference across health, social care, housing, and community settings. The findings show that the quality of these interactions shapes whether older adults disclose abuse, remain engaged, and regain control. The recommendations set out how professionals can respond more effectively to older people's specific needs.

1. Create Safe, Person-Centred Environments

- Foster an atmosphere of non-judgmental listening where older people feel heard and believed.
- Prioritise relational in addition to procedural interactions—move beyond "tick-box" approaches and clearly explain the purpose of any assessments.
- Avoid making assumptions about an older person's gender identity and sexuality – ask about the older person's gender and sexual identity and the gender of partners.

2. Use Exploratory and Accessible Language

- Avoid formal terms like "domestic abuse" early in conversations; instead, use phrases like "difficulties at home" or "feeling safe at home."
- Introduce terminology around domestic abuse gradually and at a pace led by the older victim-survivor.
- Translate professional terminology into everyday language that resonates with older adults' experiences.

3. Be Proactive and Empathetic

- Do not wait for older people to disclose—use professional curiosity to gently explore signs of abuse.
- Be mindful of gendered dynamics—avoid showing undue sympathy to abusive partners who appear frail or dependent.

4. Build Trust Through Continuity

- Wherever possible, ensure older people can see the same practitioner regularly to foster trust.
- Respect the older persons pace—recognise that disclosure often unfolds over multiple conversations.
- Where continuity is not possible, ensure clear handovers so older adults are not left retelling their story.

5. Respect Communication and Accessibility Needs

- Ask about and respond to hearing, mobility, cognitive, and language needs.
- Offer flexible communication options (e.g., telephone, home visits, written material) and record preferences on referral forms.
- Provide information in multiple formats (large print, easy read, digital and verbal).

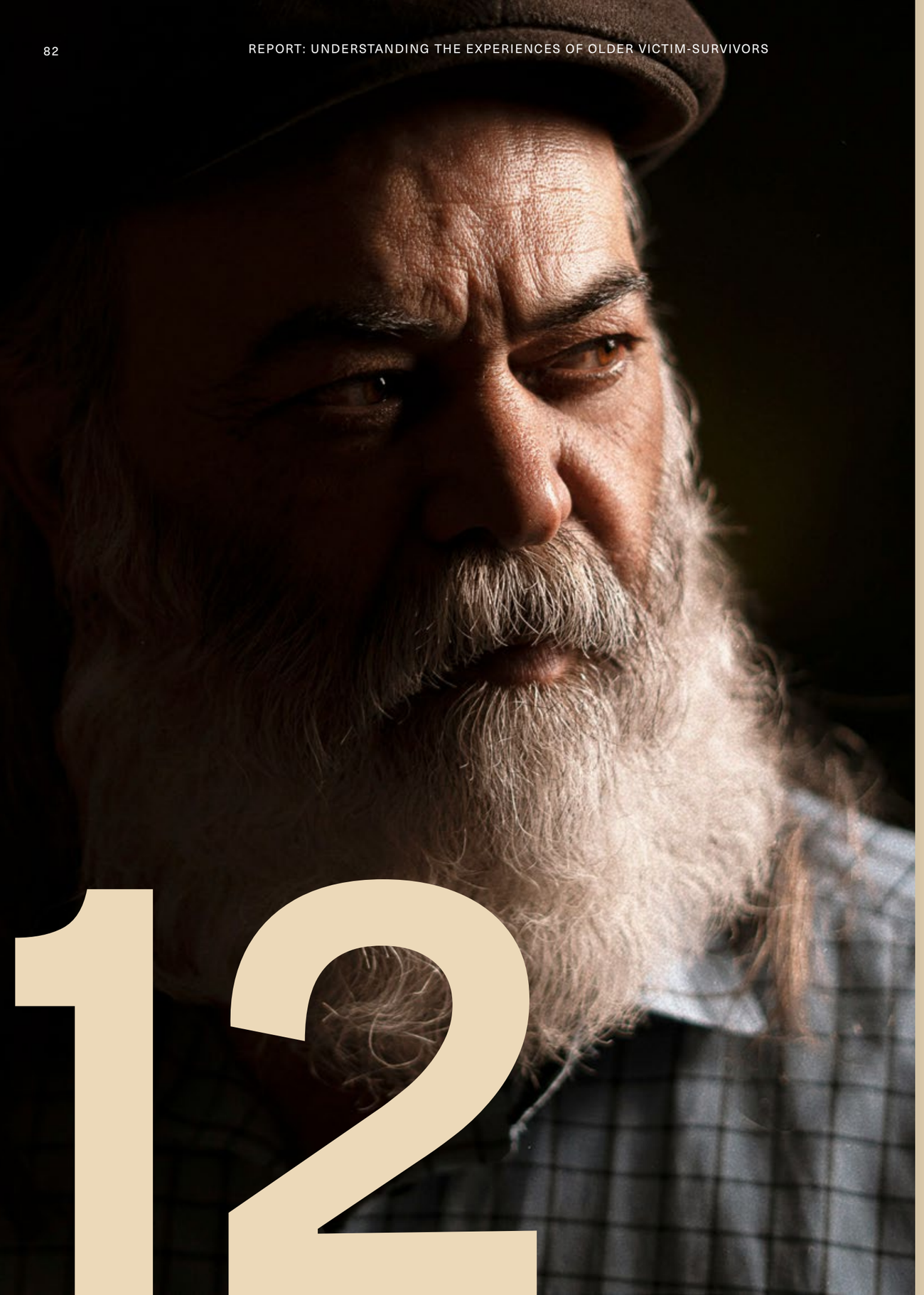
6. Ensure Confidentiality and Clarity

- Clearly explain confidentiality policies and what will happen with disclosed information.
- Avoid discussing sensitive issues in the presence of family or others unless explicitly invited to do so by the older victim-survivor.

7. Support Practical Needs and Navigation

- Help older victim-survivors understand and access entitlements (housing, benefits, legal support).
- Offer help with filling forms, making calls, and navigating bureaucratic systems— particularly for those unfamiliar with digital processes.
- Signpost proactively to advocacy services where additional support is needed.

These recommendations aim to dismantle the emotional, structural, and generational barriers older adults face in accessing safety and support. By embedding age-informed, trauma-sensitive principles into both service design and frontline practice, organisations and professionals can make a meaningful difference in the lives of older victim-survivors.



12

References

This section presents the sources that inform the study, drawing together empirical research, policy documents, and theoretical work that shaped the analysis and contextualised the experiences of older victim-survivors.

Bows, H., Pullerits, M., & Brennan, I. (2025) 'Domestic abuse in later life: A secondary analysis of the crime survey for England and Wales', *European Journal of Criminology,* Vol. 0(0).

Campbell, W.K., Bonacci, A.M., Shelton, J., Exline, J.J. and Bushman, B.J. (2004) 'Psychological Entitlement: Interpersonal Consequences and Validation of a Self-report Measure', *Journal of Personality Assessment,* 83(1), pp. 29–45. doi: 10.1207/s15327752jpa8301_04.

Cicirelli, V.G. (2010) 'Attachment relationships in old age', *Journal of Social and Personal Relationships,* 27(2), pp. 191–199. doi: 10.1177/0265407509360984.

Cornwell, B. (2011) 'Age Trends in Daily Social Contact Patterns', *Research on Aging,* 33(5), pp. 598–631. doi: 10.1177/0164027511409442.

Dobash, R. and Dobash, R. (1998) 'Violent men and violent contexts', in Dobash, R. and Dobash, R. (eds.) *Rethinking Violence Against Women.* Thousand Oaks, CA: Sage, pp.141–168.

Dupuis, A. and Thorns, D.C. (1998) 'Home, Home Ownership and the Search for Ontological Security', *The Sociological Review,* 46(1), pp. 24–47. doi: 10.1111/1467- 954x.00088.

Giddens, A. (2024) *'Modernity and Self-Identity'.* Stanford, CA: Stanford University Press. Available at: https://www.sup.org/books/sociology/modernity-and-self-identity

Gouveia, M.J., Carona, C., Canavarro, M.C. and Moreira, H. (2016) 'Self-compassion and dispositional mindfulness are associated with parenting styles and parenting stress: The mediating role of mindful parenting', *Mindfulness,* 7(3), pp. 700–712. doi: 10.1007/s12671-016-0507-y.

Hestia. 2025, 'Safe Spaces', available at: https://www.hestia.org/safe-spaces

Hightower, J., Smith, G. and Hightower, H.C. (2006) 'Hearing the Voices of Abused Older Women', *Journal of Gerontological Social Work,* 46(3-4), pp. 205–227. doi: 10.1300/j083v46n03_12.

Izzidien, S. (2008) 'I can't tell people what is happening at home': Domestic Abuse within South Asian Communities – The Specific Needs of Women, Children and Young People'. London: NSPCC.

Letendre Jauniaux, M. and Lawford, HL. (2024) 'Interpersonal curiosity as a tool to foster safe relational spaces: a narrative literature review'. Front. Psychol. 15:1379330.

Lewis, T.T., Cogburn, C.D. and Williams, D.R. (2015) 'Self-Reported Experiences of Discrimination and Health: Scientific Advances, Ongoing Controversies, and Emerging Issues', *Annual Review of Clinical Psychology,* 11(1), pp. 407–440. doi: 10.1146/annurev-clinpsy-032814-112728.

Local Government Association and ADASS (2015) '*Adult safeguarding and domestic abuse'.* Available at: https://www.local.gov.uk/sites/default/files/documents/adultsafeguarding-and-do-cfe.pdf

Marcum, C.S. (2013) 'Age differences in daily social activities', *Research on Aging,* 35(5), pp. 612–640. doi: 10.1177/0164027512453468.

Marcum, J.A. (2013) 'The Role of Emotions in Clinical Reasoning and Decision Making', *Journal of Medicine and Philosophy,* 38(5), pp. 501–519. doi: 10.1093/jmp/jht040.

McGarry, J. and Ali, P. (2019) '*The Invisibility of Older Women as Survivors of Intimate Partner Violence',* in Springer eBooks, pp. 41–55. doi: 10.1007/978-3-030-16601-4_3.

Montminy, L. (2005) 'Older Women's Experiences of Psychological Violence in Their Marital Relationships', *Journal of Gerontological Social Work,* 46(2), pp. 3–22. doi: 10.1300/j083v46n02_02.

Stark, E. (2007) *'Coercive Control: How Men Entrap Women in Personal Life'.* New York: Oxford University Press.

The Roestone Collective. (2014) 'Safe Space: Towards a Reconceptualization', *Antipode,* 46(5), pp. 1346–1365. doi: 10.1111/anti.12089.

Umberson, D. and Karas Montez, J. (2010) 'Social Relationships and Health: A Flashpoint for Health Policy', *Journal of Health and Social Behaviour,* 51(1_suppl), pp. S54–S66. doi: 10.1177/0022146510383501.

Welsh Government. (2018) '*Violence against women, domestic abuse, and sexual violence: national survivor engagement framework'* [online] available at: https://www.gov.wales/violence-against-women-domestic-abuse-and-sexual-violencenational- survivor-engagement-framework.

Wydall, S. and Zerk, R. (2017). 'Domestic abuse and older people: factors influencing help-seeking'. *The Journal of Adult Protection,* 19(5), pp.247–260. doi: https://doi.org/10.1108/jap-03-2017-0010.

Wydall, S., Zerk, R. and Freeman, E. (2023) Making the invisible, visible: older lesbian, gay and bisexual victim-survivors' 'lived experiences' of domestic abuse. *The Journal of Adult Protection,* [online] 25(3), pp.167–185. doi:https://doi.org/10.1108/jap-10-2022- 0020.

Zerk, R., Freeman, E. and Roberts, J. (2024) 'Unheard Voices: Older Women's Experiences of Living with Sexual Abuse in Intimate Relationships across the Life Course', *in Contemporary Perspectives on Sexual Abuse – Disclosure, Response, and Treatment Considerations [Working Title]. IntechOpen* eBooks. doi: 10.5772/intechopen.1007022.

Dewis CHOICE

1872 PRIFYSGOL ABERYSTWYTH UNIVERSITY