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Exploring Coping Strategies Among Older Women Who Have Experienced Intimate Partner Violence During COVID-19

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A thesis submitted in partial fulfillment of the requirements for the Master of Science degree in Health Promotion

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Abstract

With the emergence of COVID-19 public health measures including the stay-at-home order, the effects of intimate partner violence (IPV) have become more severe for women while the availability of support has become hampered. The purpose of this interpretive description study was to explore coping among older women in Ontario experiencing IPV during COVID-19. 12 in-depth interviews with older women found age-related normative beliefs played a key role in how older women viewed their lives and how they looked beyond their experiences of IPV. Older women stressed how their roles as caretakers and homemakers influenced their response to IPV and that COVID-19 exacerbated feelings of lost time and loneliness. Emotion-focused coping strategies consisted of social support, and problem-focused included telephone formal services and physical activities. Women expressed a lack of appropriate services and financial limitations as barriers. They identified the need for age-appropriate services that acknowledge their unique experiences.

Keywords

Intimate Partner Violence, Coping, COVID-19, Older Women.

Summary for Lay Audience

Intimate partner violence impacts over a third of the Canadian population and can affect women at any age. During the COVID-19 pandemic, women reported facing more severe abuse than before the pandemic. This increase in severity of abuse was experienced while many services were shut down and women's access to past coping mechanisms was limited by the public health restrictions aimed at slowing the spread of COVID-19. This study explored how older women (over the age of 50) who were living with abusive partners during the COVID-19 pandemic coped. Coping is a tactic that helps someone lower the stress that comes with various situations. Through interviews with 12 older women living in Ontario between March and June in 2021 we found that the ways older women were expected to act in society influenced how they viewed themselves and their lives. Women felt they had to take care of their partners/family and/or keep up with their home, which stopped many women from leaving the abusive relationship. Older women mentioned feeling more stressed because time was slipping away from them. Older women were also lonely because of the COVID-19 public health restrictions, as they were unable to leave the house. To manage the stress from the abuse and the COVID-19 pandemic, older women relied on emotional support, from helplines. Older women also reported that support services were hard to access. In future pandemics, older women expressed that it is important there are services designed to help older women.

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Chapter 1

1 « Literature Review »

The first case of COVID-19 in Canada was confirmed in January of 2020 (Bronca, 2020). Since then, Canada has used public health measures, including a declaration of a state of emergency, physical distancing, and stay-at-home orders to slow the spread of the deadly virus. These public health measures have impacted access to services and coping strategies for all Canadians; however, not all populations have been impacted equally (Lyons & Brewer, 2021). The United Nations has identified that during pandemics and times of trauma, there is a heightened risk for women and girls (United Nations, 2020). One heightened risk for women during the COVID-19 pandemic was the increased prevalence and incidence of intimate partner violence (IPV) (Ghoshal, 2020). IPV can be understood as a pattern of physical, sexual, or emotional abuse within the context of coercive control perpetrated by an intimate partner (Tjaden & Thoennes, 2000). Researchers have attributed the increases in IPV to both the public health measures, such as provincial state of emergency and stay-at-home orders, and heightened familial stress (Evens et al., 2020; Gosangi et al., 2021; Lausi et al., 202; van Gelder et al., 2020).

It is important to note that IPV is a significant public health concern in its own right, as it impacts every aspect of women's lives (Ali et al., 2016). In Canada, approximately 44% of women aged 15 and older experience IPV at some point in their lives (Cotter, 2021). There is considerable research on the impact of IPV among younger women, including the causes of IPV, health and social implications, and coping (Jarnecke & Flanagan 2020); however, there is minimal literature exploring older women's experiences of IPV and coping. This is of concern as the world is currently facing a major demographic change. According to the World Health Organization (WHO), by 2050, the number of individuals over the age of 65 globally will be 1.5 billion, accounting for 16% of the world population, which is double the percentage in 2010 (WHO, 2007). Together the high prevalence of IPV along with the aging population underscores a need to examine experiences of IPV among older adults.

Older women experiencing IPV are underrepresented in research both prior to and during the pandemic. Moreover, according to a 2016 report published by Women's Aid, it was found that studies on IPV do not typically include women over the age of 59 (Solace Women's Aid, 2016). This exclusion has been attributed to convenience sampling in studies and more specifically recruitment methods, such as partnering with women's shelters to support recruitment, a service that is not generally utilized by older women (Solace Women's Aid, 2016). As such scarcity of research among older adults who have experienced IPV. Among studies that have explored older adults' experiences of IPV the lower age cut-off has ranged from 50 to 90 years (Solace Women's Aid, 2016). As such a lower range of 50 years of age will be used to denote older adults for the purposes of this thesis. It should be noted that 50 years of age does not conform with the broader older adult literature which typically suggests older adulthood starts at 65 years and older (Turcotte & Schellenberg, 2007); however, for there to be literature pertaining to the experiences of IPV among older adults a minimum age range of 50 years was used.

It has been reported that women cope with experiences of IPV in many ways. However, there is a dearth of literature examining coping and IPV among older adults. Specifically, there is no research to date focusing on the experiences of coping of older women experiencing IPV during the COVID-19 pandemic. Prior to the pandemic, there was minimal research and this lack of literature has been attributed to the reality that older women are less likely than younger women to report their experiences of IPV and/or seek formal services (Roberto et al., 2013). Older women's reluctance to seek support is deeply rooted in shame and humiliation, fear of having to make a major lifestyle change, guilt about abandoning an abuser in poor health, traditional values of marriage, and the need to keep family matters private (Zink et al., 2003). Research has established that older women's perspectives of patriarchal attitudes gave rise to their partners' sense of power and privilege which influences the likelihood that older women will engage with support services (Harris et al., 2012). Together these family norms of abuse and the need keep experiences of abuse within families decreases the likelihood older women will engage with support services, meaning many women cope with the abuse on their own; however, little is known about how older women are coping.

1.1 Older Women's Experiences of IPV

To understand how older women are coping with experiences of IPV, we must understand what violence typically looks like for older women. While IPV can include physical, sexual, emotional, and financial abuse, the few available studies on experiences of IPV among older adults revealed older women were more likely to experience emotional abuse compared to physical abuse. A study by Zink et al. (2005), examining IPV among 995 women over the age of 55 in Southwestern Ohio, found that 45% of women reported psychological/emotional abuse whereas controlling behaviours and threats of physical harm accounted for abuse experiences in only 2.43%, and 2.63% of cases, respectively. Beyond the different typologies of abuse, an Australian community-based study by Cations et al., (2020) of 728 women aged 70-75 followed for 21 years, reported that older women whom self-reported exposure to IPV died significantly earlier than those who did not report IPV. Together the differences in the typology of abuse and increased risk of death for older women experiencing IPV underscore a need for tailored services for this demographic. However, when Bhatia and Soletti (2019) explored the demographics of those using domestic violence services they found that services were typically accessed by women in their 20s and 30s and less often by women older than 50. This trend was consistent even when older and younger women shared similar experiences of abuse (Bhatia & Soletti, 2019). These differences in the typology of abuse, health consequences, and service use rates underscore nuanced differences in the needs of older women who are experiencing IPV.

Women stay in abusive relationships for a myriad of different reasons. One reason highlighted in the literature regarding why older women stay in abusive relationships is because of their traditional views of marriage and gender roles (Zink et al., 2003). It has been established older women are less likely to seek outside interventions for marriage/abuse or discussion of marital matters (Souto et al., 2019; Zink et al., 2003). These generational ideologies were explored in a study interviewing 38 women over the age of 55 who had experienced IPV with participants underscoring that growing up in the 1950s meant they were not encouraged to be educated and that traditional religious and family values were expected of them (Zink et al., 2003). Furthermore, these deeply

rooted views extended to their beliefs about needing to stay in their relationships regardless of the abuse. Given the unique generational ideologies older women hold, it is important to understand why different age cohorts of women stay in IPV relationships as this provides context for not only barriers to service use, but also may provide insights into why specific coping strategies are used or not used.

Another reason older adults stay in abusive relationships is largely due to caretaking roles and family pressure. A study by Dare et al., (2013) reported that younger women stay in IPV relationships because of love for their partners, seeing their situations as not as bad as others, and even not recognizing the relationship as abusive. Comparatively, older women reported they stayed in abusive relationships predominantly due to their caretaking responsibilities, pressure to uphold the family image, and fear of how adult children would react if they left the abusive relationship (Teaster et al., 2006; Zink et al., 2003). Barriers to accessing services regarding IPV include failure to recognize instances of IPV, low self-esteem, fear, or wanting to protect the perpetrator among women aged 18-45 (Petersen et al., 2005).

1.2 Older Women, IPV and Coping

Research has established that women who experience IPV develop tailored coping strategies that are useful for their contexts (Zink et al., 2003). While there are many conceptualizations of coping, perhaps the most influential theory of stress and coping was developed by Lazarus and Folkman (1984). According to Lazarus and Folkman, stress results from imbalances in perceived external and internal demands and coping is the perceived personal and social resources an individual possesses to deal with those stressors (Lazarus & Folkman, 1984). Folkman and Moskowitz (2004) went on to further explain that coping can be understood as the thoughts and behaviours used to manage the internal and external demands of situations that are appraised as stressful (Folkman & Moskowitz, 2004). This understanding of coping was selected over other theories as it is the most common theory in coping, and it focused on strategies that could be applicable in the context of IPV. Other coping theories, focused on psychological factors that promote coping or were specific to stressors, making them not suitable for this line of inquiry. As the purpose of this study was to explore coping with IPV among older women

a theory that covered a general understanding of coping was deemed most appropriate. Within Folkman & Moskowitz's (2004) theory of coping there are two types of coping: emotion-focused coping and problem-focused coping (Folkman & Moskowitz, 2004). Emotion-focused coping is described as strategies used to manage the distress associated with the problem, while problem-focused coping is strategies to manage the problem (Folkman & Moskowitz, 2004). Literature regarding coping during COVID-19 for older women experiencing IPV does not yet exist. Therefore, general coping literature was sought to gain an understanding of what is known about coping among older women experiencing IPV. The remainder of this chapter will provide a literature review of IPV, older adults, and coping covering the following topics: 1) emotion-focused coping to manage the distress; and (2) problem-focused coping to deal with the abuse. Lastly, a summary of evidence and the study's purpose will be explained.

1.3 Emotion-Focused Coping

Emotion-focused coping can be understood as strategies used to manage the distress associated with a specific problem; these strategies typically develop over time and are seen as a "philosophy of life" (Folkman & Moskowitz, 2004). While a range of emotion-focused coping has been reported by older women experiencing IPV in the United States and Canada including crying, telling someone, becoming more independent, or taking on new activities, the most common strategy was reframing the abuse (Divin et al., 2013; Souto et al., 2019; Zink et al., 2004; Zink et al., 2006). Specifically, women reported trying to see themselves, their partners, and their lives in a different light when confronted with abuse (Zink et al., 2006). Seeing the abuse from a different lens often involved women reframing the abuse experienced using positive reappraisal (Zink et al., 2006). Positive reappraisal can be understood as changing their perspective surrounding the important aspects of themselves, their abuser, or the relationship (Zink et al., 2006). For these older women positive reappraisal largely involved imagining their situations as being better than it was which allowed them to maintain their relationship while experiencing abuse (Zink et al., 2006). Social support was crucial to the reappraisal process for older women (Zink et al., 2006). When women were unable to receive the emotional support they needed at home, they would turn to friends and family, this would

allow them to reimagine themselves as stronger while enduring IPV (Zink et al., 2006). Social support comes from reaching out to others and having people to talk to, it helps women to engage in positive interactions (Zink et al., 2006). While many older women experiencing IPV reported positive reappraisal and social support as an effective strategy for coping with abuse, they noted it was most difficult to positively reappraise the abuse when they experienced verbal compared to physical abuse (Zink et al., 2006).

Older women also underscored the importance of seeking emotional support while enduring abuse. Both Zink et al., (2004) and Divin et al., (2013) reported that older women actively sought someone to disclose their abuse to and identified that informal support was preferable to formal care providers. Older women cited religion as one form of informal support. The use of religion and religious activities as an emotional coping strategy was reported in studies by both Divin et al., (2013) and Souto et al., (2019). Women in these studies found comfort in having informal support that aligned with their beliefs particularly as it relates to the permanency of marriage, as for many older women leaving their abusive partner was not perceived as an option. While the abuse caused some women to question their religious beliefs, ultimately during this time of crises, older women reported feeling comfort in turning to their church for guidance (Divin et al., 2013).

Beyond using religious communities, women experiencing IPV also reported seeking support from formal care providers such as those in health care to manage the distress associated with the abuse. However, for the most part the use of formal care providers by older women experiencing IPV was not useful. Zink et al., (2004) reported that 53% (n=20) of participants had disclosed IPV to their healthcare provider of which 95% (n=19) identified unhelpful responses to their disclosure. Unhelpful responses included being written off as complainers, health providers seeming uncomfortable, and IPV being minimized causing women to not receive the help they were seeking (Zink et al., 2004). Moreover, a study by Roberto et al., (2013) looked at the challenges in providing formal support for rural older women experiencing IPV and reported the need for discreet services as being paramount- a need that was not always met (Roberto et al., 2013). When older women who are experiencing IPV reach out to formal support to help them

address the distress they are experiencing as a result of the abuse, barriers such as inappropriate responses and inability to access resources discretely point to gap in service provision.

1.4 Problem-Focused Coping

Problem-focused coping is typically an action-based strategy designed to deal with the problem (Folkman & Moskowitz, 2004). Older women experiencing IPV identified using problem-focused coping to deal with experiences of abuse which included using routines, care duties, and substances (Lazenbatt et al., 2013; Roberto et al., 2013; Teaster et al., 2006; Zink et al, 2006). These are action-based /physical coping approaches utilized to manage the stressor itself. In a study by Zink et al. (2006), in the United States reported 10% (n=4) of older women established a routine to help them cope with the abuse. This routine included setting spatial boundaries, keeping busy with work, volunteering, and home maintenance (Zink et al, 2006). By keeping busy and sticking with routines older women were able to minimize experiences of abuse by trying to appease their abusers. Similarly, in Teaster et al., (2006) study of rural older adults experiencing IPV in the United States reported older women identified staying with their abusive partners by focusing on a different problem, which was providing care for their grandchildren. In this study older women coped with experiences of abuse by remaining focused on their need stay in the relationship to be able to be a caregiver for their grandchildren (Teaster et al, 2006).

The use of alcohol and drugs to cope with experiences of abuse was identified among older women who had experienced IPV in studies by Lazenbatt et al., (2013) and Zink et al., (2006). Lazenbatt et al. (2013) examined the coping strategies among 18 women through Northern Ireland's Women's Aid shelters and programs and more than half the participants were using non-prescription drugs and/or alcohol to cope. 66% (n=12) of participants were diagnosed as alcohol dependent (Lazenbatt et al., 2013). In the studies by both Lazenbatt et al., (2013) and Zink et al., (2006) alcohol and drugs were used by older women to cope with experiences of IPV. Both studies also underscored those older women who used alcohol and/or drugs had histories of trauma and cumulative lifetime

violence, and to these women this was a means of survival (Lazenbatt et al., 2013; Zink et al., 2006)

1.5 Summary of Evidence »

Older women experiencing IPV prior to the pandemic utilized both emotion-focused and problem-focused coping to deal with abuse. Emotion-focused coping included the use of informal support and positive reappraisal. Problem-focused coping included maintaining a routine and the use of substances. However, throughout the COVID-19 pandemic, the public health measures have limited what Canadians were able to do, with research emerging that the coping strategies used prior to the pandemic becoming severely hampered (Lyons & Brewer, 2021). This is likely true for older women experiencing IPV, as public health measures may have limited the ways in which women can engage with informal support and the ability of women to maintain a routine; however, there is currently, no literature examining coping among older women experiencing IPV during the COVID-19 pandemic. As such the purpose of this study was to explore coping among older women living in Ontario experiencing IPV during the COVID-19 pandemic.

Chapter 2

2 « Method »

The purpose of this study was to explore coping among older women experiencing IPV during the COVID-19 pandemic. This cross-sectional qualitative study used an interpretive description (ID) framework coined by Sally Thorne (1997). ID aims to generate knowledge relevant to the clinical context of applied science (Thorne et al., 2004). ID was created for nursing studies to break free of the constraints of traditional qualitative methodologies and to build more effectively the knowledge the discipline requires (Beck, 2013; Thorne et al., 2004). This type of methodology was designed to enable action from the study conducted rather than identifying truths (Beck, 2013). ID would fall under the pragmatic paradigm, as it believes there is no objectivity in the social world (Weaver, 2018). ID is unique in that it does not follow the rigorous structure of a singular methodology, but rather adopts techniques and skills relevant to that study (Beck, 2013; Thorne et al., 2004). For this study specifically, the main themes of coping and IPV were investigated while considering the uniqueness of each individual situation for each participant. As ID is grounded in action-oriented research, the goal of this analysis was to understand IPV and coping experienced by older women and in turn highlight the needed changes to practice. Within IPV research, ID was useful in determining what types of support this population needed. It is important to note while this study's goal is to identify areas for meaningful change, as different generations of populations age their needs will also change. Therefore, adaptability and consistent evaluation of needs of older adult women experiencing IPV is important.

This study was grounded in intersectionality, meaning the interconnected nature of social categorization such as race, class, and gender as they applied to individuals or groups creating an overlapping system of discrimination or disadvantage (Colombo & Rebughini, 2016). Kimberle Crenshaw (1991) applied the concept of intersectionality to violence against women, as this issue crosses many different social issues.

Ethics approval was obtained from Western Research Ethics Board in March 2021 prior to recruitment and initiating communication with participants (letter of approval

Appendix A). This study was part of a large study known as EMPOWER. EMPOWER also looked at coping strategies of women who had experienced IPV but did not focus on a specific age cohort. This study differed in that it only included participants who were 50 years of age or older.

Recruitment

Recruitment for this study was done in the province of Ontario, from March 2021 to June 2021. In 2019 Ontario had a population of 14.6 million people (Ontario Ministry of Finance, 2020), 2.5 million (17.2%) of the population was 65 years of age or older. The number of older adults in Ontario is expected to nearly double by 2045 and account for 4.5 million people (23.3%) (Ontario Ministry of Finance, 2020). At the time of recruitment for this study, the province of Ontario was in multiple different stages of public restrictions and stay-at-home orders depending on the region (Lawson et al., 2022). Participants from larger metropolitan regions may have been in full stay-at-home order with no access to non-essential services (i.e., restaurants, malls, some shelters etc.), while others may have had access to public spaces at reduced capacity (i.e., 25% or less of the total capacity) (Lawson et al., 2022).

Recruitment for this study used Kijiji advertisements across Ontario, as well as snowball sampling strategies. Facebook advertisements in various groups were also posted to recruit participants (recruitment poster Appendix B). Due to the sensitivity of this topic, those who wished to participate contacted the researcher via email. Recruitment was completed on June 16th, 2021, and a total of 1,094 advertisements were posted resulting in the participation of 12 women who met the inclusion criteria (advertisement summary Appendix C).

Eligibility

To be eligible to participate in this study participants must: (1) be a woman who lived in Ontario, (2) were 50 years of age or older, (3) experienced IPV within the previous year and (4) had access to a safe phone and/or computer. The inclusion of only women in this study was selected as there is mounting evidence that experiences of abuse differ based

on gender (Government of Canada, 2021). A lower age range of 50 years was selected as this is in line with the classification of older adults in the IPV literature. Participants were eligible if they had experienced any form of physical, emotional, or sexual abuse in the last year (12 months) which was assessed using the Abuse Assessment Screen (AAS) (Soeken et al., 1998). The AAS a four-question validated tool that assesses physical, emotional, and sexual abuse as well as coercive control was used to determine abuse experiences (Soeken et al., 1998). To determine if participants had access to a safe phone and/or computer they were asked if their devices were safe via a yes or no question. This global question was utilized as previous research in the area has identified that women experiencing violence are experts at knowing how to keep themselves safe and if their devices are safe (Eden et al., 2015; Glass et al., 2017).

Procedures

Participants who were interested in participating emailed the researcher and were provided with a link to a survey, which contained all eligibility criteria, and informed consent. Simultaneously, a password to access the survey was sent via telephone to create a two-factor authentication to control for robots. During recruitment, it became evident that receiving the password via text to access the survey was a barrier to participation for many women. As such, when interested participants emailed the researcher to express interest, the researcher would proceed to booking the interview. Once the interview was booked an email containing the letter of information (LOI Appendix D) and interview guide were sent to participants. Therefore, eligibility screening was conducted verbally over the phone instead of referring participants to a link, prior to the start of the interview. Once eligibility was confirmed, the process of informed consent (Appendix E) was conducted followed by the interview. All interviews were booked at mutually convenient times for the participants and interviewers.

Safety Protocol

To minimize the harm of this study, women were asked to ensure they are in a safe place and were informed that they could reschedule their interview if they were no longer able to attend. Prior to the interview, after the consent process, a safety plan was created to

protect the participants from intrusion as recommended by Ford-Gilboe et al., (2006). Women were informed of the safety topic, which was the weather. They were told if it ever became unsafe for them to conduct the interview to begin speaking about the weather and I, the interviewer, would know it was no longer safe to continue. It would be decided prior to the interview if the interviewer would stay on the line until it was safe to resume or terminate the interview if/when the safety topic was used (safety protocol Appendix F). If the online survey was used to collect eligibility information, there was a quick escape button that redirected women to the google homepage.

Participants

At the start of the interview a short demographic survey was completed verbally (Appendix G). The sample consisted of 12 Canadian women living in Ontario, aged 50-67 with an average of 53.75 years (SD=4.25), and primarily living in large urban centers (75%, n=9). In total, 58% (n=7) completed post-secondary education, 8% (n=1) had some post-secondary education, and 33% (n=4) completed high school. Average household income (pre-COVID-19) was reported as less than CAN \$19,999 by 8% (n=1), CAN \$20,000-\$49,999 by 33% (n=4), 42% (n=6) reported CAD \$50,000 or greater, and 8% (n=1) reported greater than CAN \$100,000. Most women identified as living with their partners (50%, n=6), and 58% (n=7) had children. Only 8% (n=1) lived with both their partner and children. Although all participants were required to identify as women to be eligible for this study, gender diversity was observed as 25% (n=3) identified as trans-women. Most women identified as heterosexual, 67% (n=8), 17% (n=2) identified as pansexual, and 17% (n=2) did not specify. Full demographic characteristics of women who participated can be found in table 1.

Table 1: Demographics Variables

Demographic Variables	Total
	n=12
	n(%)
Gender	
Women	9 (75)
Trans women	3 (25)

Education level	
High school	4 (33)
Some college or university	1 (8)
College/ University	7 (58)
Indigenous	
Yes	1 (8)
No	11 (92)
Sexuality	
Heterosexual	8 (67)
Pansexual	2 (17)
Not defined	2 (17)
Marital Status	
Single	3 (25)
In a relationship not married, common law or engaged	3 (25)
Married, common law, engaged	3 (25)
Divorced or separated	3 (25)
Household income	
Less than \$19, 999	1 (8)
\$20,000-49,999	4 (33)
\$50,000-99,999	5 (42)
Greater than \$100,000	1 (8)
Not defined	1 (8)
Type of Community	
Large urban center (100,000 people or more)	9 (75)
Urban Center (30-99,000)	2 (17)
Rural (30 000 or less)	1 (8)
Children	
Yes	7 (48)
No	5 (42)
Children's Living Situation	
Live with me full-time	1 (8)
Live with me part-time	1 (8)
Do not live with me	5 (42)
Does not apply	5 (42)
Living Situation	

Live alone	4 (33)
Live with partner	6 (50)
Live with partner and children	1 (8)
Other	1 (8)
Essential worker	
Yes	1 (8)
No	11 (92)

Interview

Semi-structured interviews were used and ranged from 24-59 minutes, with an average of 39.8 minutes ($SD=8.75$). A semi-structured approach was selected as it allowed those participating the freedom to express their views in their own words (Cohen & Crabtree, 2006). The questions asked were all open-ended and focused on coping during COVID-19. The semi-structured interview had three parts: (1) context, (2) coping strategies used, what made it difficult to cope, and (3) what they needed to improve how they coped (see Table 2 Semi-structured interview guide). Upon completion of the interview, women were provided with a \$15 honorarium in recognition of their time and contributions. After the interview was completed, all recordings were transcribed verbatim.

Table 2: Interview Guide

Context: set the stage for participants lives pre and post COVID-19	1. How are things going for you at home?
	2. Can you describe how things in your life might have changed when the COVID-19 pandemic started?
	3. What helped you to cope during the COVID-19 pandemic? a) When you were in lock down b) Probe: IPV experiences
Coping and Difficulty to Cope: looked to understand what strategies are used by women to manage the stress associated with IPV during the stay-at-home order	4. What made it more difficult for you to cope during the COVID-19 pandemic? a) During the stay-at-home order b) Probe: IPV experiences
	5. What would have helped you to cope better? a) What did/do you need? What was helpful? What was not helpful? b) During the stay-at-home order c) Probe: IPV experiences

	6. What do you think would have help you to bounce back from difficulties in future waves of the COVID-19 pandemic?
	7. Of the coping strategies you mentioned today, which is the most important?
<p>What they needed to improve how they coped: focused on the needs of participants, was key in providing recommendations for improvements.</p>	8. How should/can support for coping strategies be delivered? By whom? When? How often?
	<p>9. Women in similar circumstances suggested the following coping strategies (insert list based on analysis). Which of these, if any, are important to you?</p> <p>a) What is it about is makes it so important?</p> <p>b) Other coping strategies?</p>
	<p>10. Women in similar circumstances suggested the following best ways to support women to cope in terms of resilience in a pandemic (insert list based on analysis). Which of these ‘best way(s)’ would be most important to you?</p> <p>a) Can you suggest any other ‘best ways’ to support women?</p> <p>b) What is it about that particular way that makes it so important?</p>
	<p>11. To what extent has your income changed during COVID-19? Please specify (higher/lower/same)</p> <p>a) What was the impact of this income change on your relationship?</p> <p>b) What was the impact of this income change on your coping?</p>
	12. What else haven’t we asked about with respect to coping and coping strategies during the pandemic that we should know?

Data Analysis

Interpretive description requires the researcher to consistently ponder, question, and try and make sense of the themes that are emerging in the data (Thorne, 2004). There were three steps used in interpretive description coding; (1) identifying themes, (2) determining the relationship between the themes, and (3) repeating the first two steps until there was an understanding of the similarities and differences. The first step was to identify each component of the presented data and determine how they are individual and

how they worked together; this process continued until there was a sense of clarity rather than an organizational structure (Thorne et al., 1997). This was achieved through open coding followed by line-by-line coding. Open coding in my study was the process of identifying major themes during the interviews and defining them. Line-by-line coding was the process of going through the transcripts and attempting to clarify the themes that had emerged (Charmaz, 2006). Line-by-line coding was utilized to verify the themes that emerged from the results. Once this was completed, using axial coding, the process of examining the relationship between the emerging themes began to yield insight into the logic and flow of the findings (Thorne et al., 2004). To examine the relationships, I went through multiple iterations of coding and made the necessary changes to themes and definitions, then completed full analysis. The idea was to continually work with the data until it moved from something that was self-evident to that which was not previously known (Thorne et al., 2004). The purpose was to make sense of all the commonalities and variations that were raised within the data (Thorne et al., 2004).

2.1 Approaches for Creating Authenticity

The four components of data trustworthiness according to Guba and Lincoln (1989) were utilized throughout this study and include credibility, transferability, dependability, and confirmability. Credibility refers to the confidence in the ‘truth’ of the findings (Guba & Lincoln, 1989). There were three primary strategies used to ensure credibility, (1) prolonged engagement, (2) peer-debriefing, and (3) reflexive journaling. Prolonged engagement is understood as the extended period spent with participants or the data (Terrell, 2016). In my study, interviews were transcribed by myself verbatim, this helps with credibility as the themes established developed from spending a lot of time with the data rather than reading it once. Peer debriefing adds to research credibility as it involves engaging with colleagues about methodology and data interpretation (Lincoln & Guba, 1989). In my study, my supervisor served as a qualified, impartial colleague whom I shared my thoughts and data interpretation with. Reflexive journaling was another strategy I used to ensure the credibility of my research. During the data collection, and coding stages, I would take notes and review them in-between interviews and after. I would note themes identified right away during the interviews, and I would compare to

see if I had similar ideas during other interviews. This allowed me to evaluate my thinking and understanding of the themes that I would notice right away. Reflexive journaling was also a way to notice when themes began to repeat and therefore reach saturation.

Transferability is understood as to how similar the meanings that are interpreted from findings to the experiences of others (Guba & Lincoln, 1989). In my study, the findings could be understood to represent women over the age of 50 who experienced IPV during the COVID-19 stay-at-home order in Ontario, Canada. It is important to recognize that my findings are not representative of all older women in Canada, or even in Ontario as my sample lacked the representation of women in rural locations. Some elements of the finding may be representative of older women experiencing IPV, but the stories and experiences are not generalizable to an entire population. The descriptions used to set the stage for the findings presented, are to ensure the appropriate transferability of the results.

Dependability is the idea that if someone else were to do the same research would they obtain similar results (Guba & Lincoln, 1989). Guba & Lincoln (1989) also argued that ensuring credibility is the primary means of establishing dependability. It is difficult to ensure dependability in ID research as my understanding and perspective of IPV and aging has the ability to influence the results. In my study to ensure the dependability of the result, I consulted with my thesis supervisor regarding what I saw in the data. According to Terrell (2016), the process of consulting with someone is external auditing.

The last component of trustworthiness is confirmability. Confirmability is centered around the objectivity of the researcher (Guba & Lincoln, 1989). In qualitative research, it is very difficult to separate the researcher from the research due to the interaction and relationship established between the two parties. As such the researcher's lens and interaction with the participants can influence how they interpreted the data (Guba & Lincoln, 1989; Terrell, 2016). To maintain objectivity and thus confirmability of the data, I was instructed on how to conduct interviews without leading on participants. I was given tips and advice regarding probing topics brought up by participants and limiting the subjecting of their thoughts. As qualitative data is subjected to influence from the

researcher, it is imperative that the researcher acknowledges any biases that can influence the interpretation of the findings.

2.2 Declaration of Self »

In my undergraduate studies, I did a specialization in health and aging. Throughout my four-year degree I learned about the growing older adult population and how it presents a new set of societal issues that need to be faced. These issues include but were not limited to health services, infrastructure, and policy. I learned that the issues surrounding an aging population are typically focused on quality of life, health, and creating an environment that is more equipped to meet the needs of this population. All these facets were influenced by ageist ideologies and processes. As a result, organizations like the WHO have established items such as age-friendly cities and improving quality of life through active/social programs like Cycling Without Age.

What was not focused on during my studies were the social phenomena like IPV that are typically not highlighted within the older population. My knowledge in gerontology indicates that generational norms among older women, such as the privacy in home life and gender roles could increase their risk of experiencing intimate partner violence. Older women's perspectives of patriarchal attitudes can give rise to their partners' sense of power and privilege which in turn may lead to or impact IPV (Harris et al., 2012). Therefore, I can assert that older women's patriarchal ideals may allow for the assertion of power and privilege.

While I understand the process of age from a social, psychological, and physiological perspective, I have never had to consider more unique factors that impact one's health as one ages, such as IPV. My understanding of general structures and outcomes may create a bias when analyzing data from older women. The idea that IPV occurs to primarily younger women has been something I have always believed, and from my understanding of the process of aging, it is easy to assume that IPV in later life can be less impactful.

Chapter 3

3 « Results »

“I’m embarrassed, I don’t want to say that this is happening in my home” (Woman (W)3)

Participants described the intersection of age, IPV, COVID-19, and coping. In understanding how coping was influenced by age two sub-themes emerged, normative beliefs particularly surrounding traditional gender roles as well as a feeling of limited time. Coping was influenced by COVID-19 as women identified a lack of resources, increased experiences of abuse, and pressures to stay with their abusive partners. Women identified coping through social support, physical coping, and online formal coping in the context of their age, IPV, and COVID-19. However, these contextual factors led to barriers in coping. Each of these sub-themes will be discussed in turn.

3.1 Aging

Older women described the connection between aging and their experience of IPV through normative beliefs and feeling as though they had limited time. Normative beliefs can be understood as a set of individual beliefs dictating socially what is desirable or appropriate as governed by context (Spratt et al., 2003). Older women identified traditional gender-role including homemaking, caretaking, and being there for others as their responsibility in the relationship and contributing to their normative beliefs about a women’s role and place in society. One woman described her responsibility to care for her husband by doing the bulk of the cooking and explained how over time her normative beliefs became a means for her partner to control her, saying,

...a trait we're accommodating. I mean, I don't mind getting up and cooking breakfast before [husband] go to work and having dinner on the table when [he] gets home. Even though I've worked a full day myself. It's how I was raised...I feel a woman...wants to take care of a man but...in other relationships, I've had other expectations. I mean, I do those things, but you're appreciative and you, you don't mind taking the garbage out...it starts that way. And it slowly changes until one day you're trapped in something uh controlling and mean and vicious. (W2)

This role of homemaking and caretaking was repeatedly described as the role of the ‘women’ and it was foundational to her worldview. Women also described the importance of this traditional role of homemaking caretaking as it related to supporting the health of their partners. A woman described how she has to care for her husband who has multiple co-morbidities and how her partner uses this role to further perpetrate abuse, she said,

...My husband, he isn't feeling very good. He has diabetes, and he doesn't really take care of himself. So [he] has kidney problems and heart problems, he has a lot of those and he doesn't listen. And it's been tough. [He] just have a lot of like, medical kind of checkup I have to help him with and just dealing with my husband at home, I try to keep my home nice and clean. And he likes to make it messy and even, like I tell him to keep it clean. And I think he makes it more messy just to make me angry, but it's not as bad as I think (W12).

Beyond normative beliefs that governed women’s interactions with their partners and everyday lives, most women in this study held beliefs that abuse was a private matter. Women described how the signs of abuse were obvious to those around her with friends inquiring about physical injuries, but that given her age she felt the need to make up a story to explain the injuries and that no one really pursued the conversation as it is something that is just not talked about. One woman highlighted how even though people may have assumed she was experiencing IPV she felt the need to not talk about it saying,

...You see like five spots on my arm?...[From] where he grab my arm?...Then it will turn purple after two or three days. I [say] I just fell. [Friends would ask] How'd you fall like that? ...I think they know. But nobody wants to talk to you (W3).

The normative beliefs that governed their interpersonal relationships as well as how peers were seeing their abuse contributed to many women staying in the abusive relationship. Another contributing factor that women stayed with their abusive partner is that many felt they were too old to change their relationship or ‘too late’ for them to leave. Limited time can be understood as feelings of missing out on life and running out of time to resolve

their IPV (Band-Winterstein, 2015). One woman described how feeling like it was too late to leave left her feeling embarrassment that she was still in an abusive relationship. This woman explained,

It's embarrassing as well because I should have my shit together. And now I'm starting over, you know, so it's kind of humiliating even more so being an older person because you're not where you should be... [younger women] have more time to fix stuff...I have more stress on my plate and next to no time left. (W11).

3.2 COVID-19

The older women in this study were experiencing IPV during a global pandemic, which compounded their experiences of violence. Specifically, there was a lack of resources, increased abuse, and a pressure to stay with their partners. Women described a lack of resources tailored to their age, during the pandemic. One woman who had utilized a women's shelter during a pandemic expressed frustrations with having to watch and listen to young women and children who were struggling, she explained,

Things are bad for me...I don't want to go to like a, like a woman's violence place, because I don't feel like listening to kids either... Like I have enough stress without having to listen to kids that are dealing with their losses...trying to figure out how I can fit into whatever to benefit myself, so I can get through it...but if you go into a family shelter you get help faster... So, you either get tortured with you know mental stress and no privacy and you know if you have stuff and you can't handle certain things or noise you know then it's difficult but at the same time if you bite the bullet you'll probably get a home quicker. (W11)

The concern regarding the age of women at shelters was echoed by another woman who said, "there were only three of us over the age of 50, everybody else was 20 or 25...they had a lot of rules" (W8). The lack of representation of women in similar age cohorts at the shelter meant for many women using a shelter was not an option.

This feeling those services were not designed for the needs of older adults was exacerbated by COVID-19 stay-at-home order public health restrictions which shutdown

many services. Women described feeling alone, as many support services shut down during the pandemic saying, "...no matter what was happening, I felt I had no resources...I had to make the situation as best as I could" (W1). Another woman echoed this saying, "I remember calling [the service line] they said we are closed down...due to the pandemic we have closed down our lines" (W5). When women found the few services that were available, they identified COVID-19 related changes in service meant the resource no longer met their needs. One woman who had accessed a women's shelter during the pandemic, then returned to her partner because of the state of the service, "I did go to a women's shelter...I was isolated in a bedroom, they brought food to my door...I felt like a prisoner actually...it was horrible" (W2).

Women also underscored how the COVID-19 pandemic, specifically the stay-at-home order resulted in increased abuse. One woman explained that increased time with her partner created tension resulting in increased abuse she said,

[My partner] wasn't this guy, we're fine. We get along so well. And then I think we spent so much time together and it's like, we annoy each other. And I do things like on purpose to annoy him which I admit I keep the TV loud and he was he was yell at me and he'll like drink his beer and throw his beer around and throw the food around says you pick it up. We do [it to] each other. We do things to each other just to irritate each other. I know what I know pisses him off. He knows what pisses me off. So, everybody presses everybody's buttons, the thing is when he's drunk and he gets very abusive. (W3)

Similarly, another woman attributed the increase in the frequency of abuse to being stuck at home together by stating, "... [before the pandemic] I could get away and he could get away so that he was getting frustrated and abusing me as much he always did, but not so much as when he was stuck at home more." (W10).

Despite the lack of resources available and increased abuse experienced by many women during the stay-at-home orders as associated with COVID-19, many older women felt sympathetic to the difficulties that their partners were experiencing during the pandemic. This sympathy was why some older women felt pressure to stay with their partners. One

woman whose partner lost a loved one during the pandemic described this saying, "...I just wanted this man gone several times now [laughs] but I was there, you know, and [it] was between the pandemic and death in his family and not being able to attend that death. I felt sorry for him" (W9). Another woman pointed out her partner's medical complications were exacerbated by the lack of resources available during the pandemic which made her feel like she had stay. She explained,

So back in 2019, I went to a woman shelter in there, I had some counseling, and they, they talked with me too, and they that help. But then I had to come back home, my husband got very sick, and he wanted me to come back home. So I came home. (W12).

3.3 Coping

The compounding effects of COVID-19, age, and IPV influenced the ways older women utilized emotion-focused and problem-focused coping strategies. Older women described using emotion-focused coping such as social support, and problem-focused strategies including (1) physical coping, and (2) telephone formal coping. Each of which will be discussed in turn.

3.3.1 Emotion-Focused

Social support. Older women expressed the importance of social support to help with both the pandemic and the abuse. Social support was described by older women as relying on family and friends for comfort and emotional reinforcement, it did not necessarily have to be regarding their personal circumstances but having people to talk to helped them to feel as though they were not alone. One woman described her social network by saying, "...I mean it's gonna take a lot of time for me to just heal but other than that just having a strong support network as I said and being close to my friends or my family just knowing that there are other people in my life to fulfill me and bring me happiness...That really means a lot to me" (W4). For some older women, the COVID-19 public health measures such as the stay-at-home order afforded them the time to engage with their social support systems more. For one woman, the COVID-19 stay-at-home

order increased time she had at home allowing her to reach out more frequently to her family, something she did not have time for before the pandemic. She explained,

...My family who some are in Pakistan, some are in Ontario, but in a different city, we've been able to FaceTime daily my, my brother, my youngest brother in Pakistan, who's been able to call kind of when it's night for him and morning for us, we all join the group call. So that's been really nice, especially since I'm no longer working, I can join. (W12)

Conversely, not all older women had increased access to social coping because of the stay-at-home orders associated with COVID-19, with one woman reporting feeling isolated and having no one to talk to, "I needed an ear to listen... I needed friends...there was no one ...maybe having social groups online of women going through the same thing" (W9). Another woman illustrated the importance of social support by explaining how difficult it was for her to cope as she was not seeing her family because of the COVID-19 stay-at-home order. She explained,

I mean, [my mom] supports me over Facebook Messenger and stuff, and we do talk, but it's not the same as having somebody hug you...when you want to talk about emotional pain or emotional struggles, you don't want to do it over the phone. You want to see somebody in person. (W2)

Not being able to connect with friends and family during the pandemic undermined some older women's ability to cope leaving them feeling more isolated. This sense of isolation was underscored by one woman who explained how she was unable to see people she counted on,

It was just a lot more isolating, like, I didn't get to see a lot of people um. And haven't really seen a lot of people, haven't seen my daughter tons um. She's not in she's in Toronto. We know the restrictions there, especially lately. It's been a while [pause]. Just really isolating. And sometimes when things get tense or whatever uh I get a lot of the Oh, the frustration gets taken out a lot on me

whether it's just uh attitude or something more. which is which is just more than it used to be I guess. (W1)

3.3.2 Problem-Focused

Physical coping. Physical coping, a form of problem-focused coping, not only helped older women manage everyday stress, but many reported it gave them daily tasks that they looked forward to. Physical coping is understood as action-based strategies that help manage stress and can be associated with doing activities (problem-focused coping) or emotional actions such as crying and screaming as a way to distract the mind (emotion-focused coping; Folkman & Moskowitz, 2004). Popular problem-focused coping activities during the stay-at-home order included cooking and baking as one woman explained, “baking. I mean [laughs], it sounds crazy, but it is my way to escape to escape anything and usually when I'm stuck, I mean, even before this relationship, I would bake” (W2).

Another physical coping mechanism mentioned was avoidance. While many coping methods can be seen as a means of avoiding their partners, the purposeful methods of staying out of their partner's way was highlighted by older women. One woman stated she would get out of the way by any means, saying, “...going into my room and reading and he was ranting and raving or something...Turning the TV on in the other room. Just physically walking away from them” (W10). Another woman took on extra work just to stay out of her partner's way, “I didn't want to take on the extra work but then I thought it was a way to runaway sort of” (W8). But as many public spaces were closed this avoidance strategy was not always available for all women. One woman noted, “everything is closed, I can't go hide in the mall. Or I can't go to Starbucks and sit there for two hours. That makes it difficult to run away.” (W6). This need to be able to go somewhere else during COVID-19 was reiterated by many women. Women described the importance of getting out of their houses and being elsewhere. For one woman she described the refuge she felt when outside saying, “[I] needed to be able to go out [laughs]...even just go into the...whenever I'm outdoors, I feel better” (W9).

Telephone formal coping. Many older women talked about the value of formal support offered online as an important coping mechanism. Women underscored the need to have continued access to support service with many of them wanting to be able to speak to someone directly. Being able to speak to someone was important for older women as it meant they were more likely to be directed towards resources that were tailored to their age. One woman spoke of how the assaulted women's helpline was a means of coping for her during the pandemic, she said, "...the women's helpline. They said that they can send they were looking for places for me to live. And they can find me places where like ladies or old people, same situation like myself..." (W5).

3.4 Barriers to Coping»

Women used a variety of coping strategies but identified age, financial autonomy, and technology all as barriers inhibiting their ability to cope. Women's age impacted the coping mechanisms available to them to deal with the abuse. One woman described the coping mechanism she had previously used to deal with the abuse was no longer a viable option because of her age, saying, "I used to do [physical] activity, but I feel like I'm so old now to do activities" (W7). Another woman explained how certain health consequences of abuse, particularly mental health concerns were not spoken about by her age cohort. This one described that speaking up and getting help as an older woman experiencing IPV was not viewed as acceptable,

There's no such thing as having anxiety at my age...meanwhile it's a real thing...you have to be quiet about it...younger generations can get help...they know what avenues they have they know more what their rights are. (W11)

Coping mechanisms were hampered by a lack of financial autonomy. Women described not having access or limited access to finances. One woman expressed that having shared finances was a reason for staying with her partner saying, "we bought our home together to I don't know, like we bought a home together. I haven't got down payments...I just can't walk away" (W6). Similarly, one woman highlighted how not having money of her own to rent a place to live was a barrier to leaving. She explained, "I don't have that I just don't have money for first and last" (W10).

This lack of money and control over finances was further exacerbated by existing social safety nets that did not intersect well with the needs of women because of the COVID-19 pandemic. Some women even expressed that they could not even purchase grocery items without their partners, or they could not leave because they did not have the money for rent on their own. To support individuals through financial hardships during the stay-at-home order, the Canadian Emergency Respond Benefit (CERB) was implemented. CERB was money given to eligible participants to offset the effects of lost income due to the stay-at-home orders. In this study women had other forms of income such as Ontario Disability Support Program (ODSP), and pensions. Therefore, they were not eligible for CERB funding, despite an increased need for support during COVID-19. One woman underscored this lack of funding support, she said

I really think that the government needs to do something financially for abuse victims, during the COVID. Anyways, [a woman experiencing IPV] need to have access, so we can leave, if we want to...[with] no money or no control of the money in your life, it's not like you'll walk out the door and go. (W2)

Beyond the financial impact of COVID-19 there was also a significant push for services to adapt to virtual formats such that they could still be offered despite public health guidelines. With these adaptations to virtual formats, there were challenges with the utility of the services and technology barriers for older women. One woman expressed how online services felt impersonal and did not fulfill her need for human connection, she stated, “I don't find them useful. No, I've seen my doctor on the phone. And it was useless ...it was frustrating, annoying, it was upsetting [laughs] I didn't find it good at all” (W9). Another woman highlighted how older women may not have the ability to operate the online service sphere. She explained,

I'm 52. I'm pretty old already. And then I have a friend who is 60-year-old who's getting abused. And but she says, I don't know how to use computers and I don't know how to use gadgets. And I don't know how to use like, texting...She asked me, can you text this my address and my name to this number? I don't know. I

don't have I don't have that phone. My phone doesn't take text. She had like a landline, so she didn't know what they were trying to tell her. (W3)

Older women described the normative beliefs surrounding caretaking and homemaking as key factors in their decision to stay with abusive partners. Women also described how there was a lack of resources tailored to women their age which inhibited help seeking. Women also discussed how COVID-19 resulted in increased experiences of abuse and added pressure to stay with their abusive partners as support services were operating within strict public health guidelines making them more difficult for women to access and more intolerable than the experiences of abuse themselves. Women described coping through engaging with social supports, which some women described as easier to do during COVID-19 and others describing it as more difficult. Women underscored the importance of physical coping strategies such as hobbies to fill the time and avoiding their partner, as COVID-19 meant they were stuck at home with their partners. The importance of online formal supports was identified by women, particularly supports they could speak with directly, as this enabled them to be directed to supports that were tailored to older women. Several barriers to coping were also identified including that as they aged some of the coping strategies they had previously used were no longer available, the lack of financial autonomy led them to being stuck in the relationship with this reality being exacerbated by COVID, as well as technology barriers in access virtual support services.

Chapter 4

4 « Discussion »

The purpose of this study was to explore coping among older women experiencing IPV during the COVID-19 pandemic. Age played a role in how older women viewed themselves, their lives, and responded to the abuse and interpersonal conflict. COVID-19 exacerbated the IPV experience for older women, as women were home more due to the public health measures, specifically the stay-at home order. Moreover, older women highlighted deeply rooted generational ideologies regarding homemaking and caretaking which became reasons for staying during the pandemic despite the increases in experiences of abuse. Social, physical, and telephone formal coping strategies were some of the strategies identified by older women. Older women experiencing IPV typically relied on social support; however, the lack of social interactions during the pandemic increased the feelings of isolation and IPV for some women. Physical coping that was artistic in nature such as baking, arts, and forms of entertainment were crucial for women to cope with IPV and the pandemic. The telephone/online formal support utilized by women demonstrated the benefits and deficits of the shift to digital service provision. Barriers to service use for women included the lack of tailored services for older women and a lack of financial support.

In this study, older women felt a duty to be homemakers and caretakers. These roles were viewed by these women as both a responsibility and priority during the pandemic when access to other forms of caretaking and support in the community was limited.

Homemaking and caretaking align with socially acceptable roles and normative beliefs about roles that women held that would have been dominant discourses in society when women who participated in this study were being raised (Blackstone, 2003, pp. 335–338; Sprott et al., 2003). Specifically, Zink et al., (2004) reported similar generational ideologies including traditional religious and family values encouraging roles of homemaking and caretaking. These roles were submissive in the family context, which reinforced keeping IPV as a strictly family matter (Band-Winterstein, 2015). Research has established that holding traditional roles, regardless of age, and valuing privacy in family matters are associated with staying in abusive relationships (Band-Winterstein,

2015; Edwards & Dardis, 2020). However, unique to this study were the ways in which older women described how these traditional gender-roles were further weaponized against in the context of a pandemic, such as being expected to take care of ill partners and maintain their homes as there were no other options for outside help during the pandemic.

Older women in this study reported feeling tired and out of options regarding what to do about their experiences of IPV. They felt time had slipped away and were embarrassed they had lived in an abusive relationship for so long. Previous research has reported that older women experiencing IPV commonly feel both physical and mental exhaustion and report frustration for time lost (Band-Winterstein, 2015). According to Band-Winterstein (2015), at the end-of-life, women evaluate events, experiences, and accomplishments which were mostly overshadowed by their experience of IPV. Band-Winterstein (2015) found that during the time in which women experienced IPV they sensed a time freeze, in which they are focused on the current events in their lives. As end-of-life approached, everything about their lives became more immediate and pressing. Older women then attempted to fulfill themselves and leave something meaningful behind (Band-Winterstein, 2015). Interestingly, the women in my sample, who were 50-67 years of age, expressed similar feelings of lost time as the women in the Brand-Winterstein (2015) study who were 60-84 years of age. The similarities in the feeling of lost time between the two studies could be explained by women in my sample also dealing with the COVID-19 pandemic. Being trapped at home gave older women more time to reflect upon their lives, perhaps, exacerbating feelings of aging.

Older women in this study stressed that due to COVID-19, there was a lack of resources available to them. Women explained how shelters had restrictions and isolation measures that made existing services unhelpful. Specifically, the isolation requirement in shelters and the typically younger demographic using shelters made older women uncomfortable in shelters which many women said influenced decisions to return to their abusive partners. While research has established the public health measures enacted to contain the COVID-19 pandemic were successful in achieving this goal, there were unintended consequences. The public health measures disproportionately disadvantaged certain

groups, with women experiencing IPV being one of them (Lyons & Brewer, 2021). Services that would normally be available to support women experiencing IPV were operating at reduced capacity and using alternate digital formats during the pandemic (Lyons & Brewer, 2021). There were also reports of shelters triaging who could use their services, with priority given to those experiencing the most significant forms of abuse and those with children (Mantler et al., 2021). This reduction in available services to women experiencing abuse contributed to women not wanting to engage with existing services out of fear they would not be helpful.

A lack of available services for those experiencing IPV is not unique to the COVID-19 context. In Teaster et al., (2006), lack of resource availability hindered older women's ability to manage the stressors associated with experiencing IPV, further limiting women's ability to reach out for help. Resources that were available had provided online options, but these were not accessible to women who did not have secure devices or felt online means were impersonal. Moreover, pre-pandemic research by Divin et al., (2013) demonstrated that lack of work experience affected the ability of older women to reach out for help when it comes to IPV, as they did not have the ability to access resources without being surveilled. The COVID-19 restrictions worked together to decrease the availability of and ability to access the already limited resources for older women experiencing IPV.

Another unintended effect of COVID-19 for older women in this sample was increased abuse by their partners. Increased stress leading to amplified abuse was reported by women in this sample, with increased time with partners due to the stay-at-home order being identified as the primary stressor. This is consistent with studies by Gosangi et al., (2021), and Lausi et al., (2021) which found a higher incidence and severity of physical IPV, and an increased prevalence of emotional abuse during the COVID-19 pandemic. The increased abuse was associated with an increase in life stressors such as fear of COVID-19, lost jobs, reduction of finances, impact on social interactions, and other physical and psychological stressors (Lausi et al., 2021). Despite this increased abuse, women in this study stayed with their partners during the pandemic because they felt

obligated to care for their partners because of existing physical or mental health conditions.

Coping strategies to manage the stress associated with the stay-at-home order and IPV for women in this study relied on emotion-focused coping strategies such as social support from family and friends, and problem-focused coping including physical strategies such as baking, cooking, and arts, and reaching out to formal services. It has been underscored older women experiencing IPV tend to use strategies that are both social and physical in nature but rely on social and psychological methods such as crying, screaming, and meditating (Zink et al., 2006). Women often seek emotional support from others such as family and friends, imagine their situation as better than it is, set a routine, and establish physical and psychological boundaries (Zink et al., 2006). However, due to the closures of public buildings during the pandemic, including malls, gyms facilities, stores, and restaurants it was noted that older women used emotion-focused coping strategies such as social support, this could be due to the lack of availability of physical-based strategies.

Emotion-focused coping including social support for women in this sample consisted of calling, messaging, and video chatting with friends and family to minimize feelings of isolation due to prolonged time at home. The emotional support experienced from talking to family and friends allowed women to feel like they had others looking out for them. This study found that reaching out to family and friends as a means of coping with both IPV and the pandemic did not mean that women have disclosed their IPV, some women expressed that their inner circle knew, while others said that no one knew. Zink et al., (2006) similarly found that older women who stay with abusive partners do reach out for outside help whether that be friends, family, or community as a means of coping, but that study did not specify the extent to which women discussed their IPV.

Problem-focused strategies including physical coping strategies are another means of managing stress associated with IPV (Zink et al, 2006). In my study, older women utilized strategies such as baking, cooking, watching TV, doing art activities, and staying out of their partners' way. Studies regarding physical coping mechanisms of older women not in times of COVID-19 relied on routine to help them cope, this includes

homemaking, keeping busy with work, volunteering, and exercising (Rizo, 2016; Zink et al., 2006). Closures of public facilities to mitigate the spread of COVID-19 limited women's ability to work, volunteer, and exercise therefore limiting the options they had for coping. Other coping strategies highlighted in the literature include the use of alcohol, drugs and other distraction and avoidance strategies (Lazenbatt et al., 2013; Rizo, 2016). Interestingly, in the study by Rizo (2016), it was reported that less common strategies were those that involved artistic expression including but not limited to, drawing, cooking, and baking, reading, watching TV, and focusing on pets. Older women in this study reported relying on activities that were artistic in nature. Two reasons could be provided for this difference, the first being this study was conducted during COVID-19 in which activities outside the home were limited. The second reason is the age of the sample. In Rizo (2016), the participants were 18-64 years of age, and in this study, participants were 50-64. It is important to understand when and why women experiencing IPV shift to using artistic methods and how to better support available coping methods during public health restrictions such as stay-at-home orders.

In response to COVID-19 restrictions, many services geared towards women experiencing IPV shifted their services to online delivery or included online components. Older women in my sample described the use of online formal services and expressed the benefits and drawbacks of these services which included helplines, and web-based chats with services. According to women in my sample, the benefits of online formal support included having a convenient means of talking to someone as well as being offered assistance with specific concerns. The use of helplines was observed throughout the pandemic for those experiencing IPV. The Vancouver domestic crisis line experienced a 300 percent increase in calls during the pandemic (Kaukinen, 2020). This suggests that helplines were a viable option for support during the pandemic.

Women in my study highlighted their age, lack of financial autonomy, and challenges with technology as barriers to coping. Women expressed that the financial assistance they were receiving did not sufficiently support them due to increased costs of living. Women also expressed how the resources to support people during COVID-19 did not seem to be geared towards older women. Financial difficulties for older women can be caused by

lack of employment, lower-paying jobs, and a lower pension to support them later on (Hing et al., 2021; Kaukinen, 2020). While the CERB was able to supplement the reduced income for people who were unable to work during the pandemic, many older women were not eligible because their income came from Ontario Disability Support Program (ODSP) and pensions. While the amount of money these participants had may not have been directly impacted by the COVID-19 pandemic, the need for financial support stems from needed autonomy from their partners with whom they have been spending an increased time with. Abusers were aware of the financial need due to work closures and/or decreased hours as a result of the pandemic and may have confiscated and/or restricted their access to funds from their partner to exert financial control (Roesch et al., 2020). During COVID-19, older women were at home more which increased their feelings of wanting to leave but their income was insufficient to make this a possibility.

The shift to virtual service options to adhere to COVID-19 restrictions was not without its limitations, particularly for older women in this study. Women experiencing IPV may face structural and practical barriers when accessing digital services while sheltered in place. Older women in this study noted that while they themselves did not struggle with technology, which is not surprising as part of the recruitment for this study was accessing the advertisement online; however, they acknowledged that older women whom they knew have expressed difficulties with technology. They also noted that online services at times felt impersonal. Emezue (2020) outlined other technological issues regarding IPV, including connectivity issues and no technology/low technology situations that would in turn cause accessibility issues. These problems can be further exacerbated in rural communities, among low-income users, and older adults who may be unfamiliar with technology (Emezue, 2020). Similarly, to my study, Emezue (2020) also highlighted women's concerns with using digital resources which were found to be impersonal for discussing matters associated with IPV. It is not understood how the transition to online resources impacts women over the age of 65 who are experiencing IPV, and alternative methods for them should be considered during future stay-at-home orders.

These findings in the context of the larger body of available knowledge provide insight related to older women, intimate partner violence, COVID-19 and coping. This leads to

recommendations about how to better support this unique cohort of women. The women in this study provided insight and recommendations for how policymakers, the gender-based violence sector, and the public could better support them (see Table 3). Services designed to support women experiencing IPV therefore should account for age and prevailing norms. In doing so these services would be ensuring that older women feel comfortable and supported when accessing these resources.

4.1 Limitations and Future Research »

The limitations of this research should be considered to contextualize the findings. The limitations include (1) the method of recruitment, (2) who was able to participate, (3) the type of sampling, and (4) the cross-sectional approach of this study. The recruitment of this sample was via Kijiji, which limited the age of the sample to women who were technologically savvy as some women may not have the technological means or see the purpose of such a website. Future research should explore how to include the perspectives of older women (65+). Given the nature of the study, it is possible that women experiencing more severe forms of IPV during COVID-19 did not participate because of the increased abuse and the coercive control prevented them from safely accessing devices. Further, this study relied on convenience sampling within the province of Ontario in which participants who saw the advertisement on Kijiji and wanted to participate were able to do so. As such our sample is largely Caucasian women, in their early 50s, living in urban locations and does not reflect the Canadian population. Future studies should use purposive sampling to ensure that participants more accurately reflect the Canadian population. The cross-sectional approach of this study meant that how participants coped was in part a by-product of the stay-at-home order during COVID-19 public health response. A longitudinal approach that would have followed participants throughout the changes of rules and regulations would have captured a more complete picture of how older women coped and responded to COVID-19 and their experience of IPV.

Table 3: Recommendations for Supporting Older Women Coping with Intimate Partner Violence During the COVID-19 Pandemic

1. It is imperative that public health guidelines consider the needs of older women who are experiencing violence and mitigate the risk of unintended consequences
2. There is a need for greater public awareness and education on how IPV intersects with families and roles for older women.
3. Domestic violence services should consider tailoring specific resources to better meet the needs of older women experiencing IPV.
4. Governments should consider domestic violence shelters and other IPV-related services as essential during pandemics to ensure they are fully operational and available to women who need them.
5. There is a need for continued public education on the signs of abuse and how to safely discuss this with family/friends.
6. Governments need to consider providing better subsidies and access to financial resources so women who want to leave abusive relationships can do so without the financial barrier.

Chapter 5

5 « Conclusion »

Older women experiencing IPV during COVID-19 described the role of generational normative beliefs around caretaking and homemaking, in influencing their experiences of abuse and likelihood of staying in the relationship. Older women also described using problem-focused strategies such as artistic coping and avoidance coping strategies as they were compatible with COVID-19 public health restrictions. The emotion-focused coping of social support, particularly engaging with family and friends, was easier for some women during COVID-19 as they had more time, but more difficult for others as their abuser was always around. Older women described the importance of having access to support where they could speak with a person, as this resulted in them being directed to more age suitable services. Barriers to coping for older women experiencing IPV included that as they age some of their previously used coping mechanisms were no longer available (i.e., physical activity). Women also identified a lack of financial autonomy and technological barriers as inhibitors to leaving and accessing resources, respectively.

The findings of this study are consistent with the existing literature regarding the coping strategies older women employ, such as the roles of homemaking and caretaking, social, and physical coping. This study was better able to identify women's feelings regarding online coping strategies and formal resources while reiterating the importance of social support. This study also identified how COVID-19 restrictions challenged the existing coping strategies typically used by older women and were compounding to their IPV experience as they spent more time with their partners. A gap in existing services, specifically the use of technology and age-appropriate services, was highlighted which resulted in important recommendations including considering the needs of women experiencing IPV when deciding on public health measures and deeming women's shelters and other services as essential. Public awareness about how IPV intersects with family and roles of older women and public education on IPV and how to recognize and discuss it with family and friends. Other recommendations include domestic violence should consider tailoring resources to meet the needs of older women, and the

government should consider providing subsidies and financial resources so women can leave IPV relationships without financial barriers.

This study underscored older women who found existing resources, such as women's helplines, to be useful to them during the stay-at-home order. Yet, these services did not consider that older women have ideologies that are deeply rooted in traditional gender roles and feeling the need to care for a partner makes it difficult for them to leave the abusive relationship. It is important that service providers understand that older women experiencing IPV have found ways to cope that are directly related to traditional women's roles. Service providers should recognize that homemaking and caretaking is a priority for some older women; therefore, finding ways to support older women in either leaving these roles within their relationship or fulfilling them so they can leave.

Coping strategies for IPV among older women was heavily reliant on social and emotional support. However, older women may still struggle to disclose IPV to their family and friends. Identifying IPV in older age can be difficult as women become physically frail and increasingly exhausted. Being able to identify signs of psychological and emotional IPV among older women and ensuring they feel heard can impact how these women feel about themselves and generally improve their outlook on life. Social and emotional support needs to not only be provided online but also in person. In-person social interactions allow women to be able to escape their physical environment. Financial support was also important for older women experiencing IPV as older women may stay in abusive relationships due to a lack of available finances. Older women who live off of subsidies or pensions were not making a sufficient amount of money and may lack savings. These financial disparities coupled with IPV limited older women's ability to cope and were a major reason they stayed.

Research has been robust in trying to uncover the IPV experiences, consequences, and ways of coping among young women but has lacked focus on older women. Assuming homogeneity in IPV experiences results in critical gaps in understanding, gaps that this study sought to fill. IPV can be experienced by women at any age, however, there is a cumulative effect that can exist as women age (Roberto & McCann, 2021). Further

research is needed on older women's experiences, particularly their ability to cope when specific coping strategies become unavailable, how differing generational beliefs influence the coping strategies, and the integration of evidence to formal supports designed to meet the needs of older women experiencing IPV, both during pandemics and beyond.

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Appendices

Appendix A: Ethics Letter of Approval



Date: 3 March 2021

To: Dr. Tara Mantler

Project ID: 116226

Study Title: Impacts of COVID-19 Physical Distancing on Women Experiencing Intimate Partner Violence at Home

Application Type: NMREB Amendment Form

Review Type: Delegated/Full Board

Meeting Date / Full Board Reporting Date:

Date Approval Issued: 03/Mar/2021 15:46

REB Approval Expiry Date: 28/Jul/2021

Dear Dr. Tara Mantler,

The Western University Non-Medical Research Ethics Board (NMREB) has reviewed and approved the WREM application form for the amendment, as of the date noted above.

Documents Approved:

Document Name	Document Type	Document Date	Document Version
Mantler NMREB116226 Interview LOI REB Jan 19, 2021	Letter of Information	21/Jan/2021	4
Mantler NMREB116226 Recruitment Text REB Jan 19 2021	Recruitment Materials	21/Jan/2021	4

REB members involved in the research project do not participate in the review, discussion or decision.

The Western University NMREB operates in compliance with the Tri-Council Policy Statement Ethical Conduct for Research Involving Humans (TCPS2), the Ontario Personal Health Information Protection Act (PHIPA, 2004), and the applicable laws and regulations of Ontario. Members of the NMREB who are named as Investigators in research studies do not participate in discussions related to, nor vote on such studies when they are presented to the REB. The NMREB is registered with the U.S. Department of Health & Human Services under the IRB registration number IRB 00000941.

Please do not hesitate to contact us if you have any questions.

Sincerely,

Kelly Patterson, Research Ethics Officer on behalf of Dr. Randal Graham, NMREB Chair

Note: This correspondence includes an electronic signature (validation and approval via an online system that is compliant with all regulations).

Appendix B: Kijiji Recruitment Poster

Title: <ul style="list-style-type: none">• Short research opportunity with \$\$\$! Women only• Survey + interview with compensation!• Something else of the sort that stands out & shows off that we offer compensation... be creative!
Category: <ul style="list-style-type: none">• Post in popular categories like jobs, furniture, volunteer, etc.
Description: <ul style="list-style-type: none">• Western University researcher invites you to participate in a 30-45-minute interview, by phone- if you are a woman who has experienced intimate partner violence during the COVID-19 pandemic, are 50 years of age or older, and have access to a safe computer/smart phone. Participation is voluntary and anonymous. A \$15 e-gift-card is offered to participants wishing to participate in an interview. If you want to learn more, you can email Christina at [REDACTED] <p>Do not alter this text except for formatting!</p>
Tags: <ul style="list-style-type: none">• Gift card, women, research study, survey, gift certificate

Appendix C: Advertisements Summary

NUMBER OF ADVERTISEMENTS IN KIJJI CATEGORIES (ONTARIO)

REGIONS	Buy & Sell	Jobs	Services	Community
464	464	38	208	370
TOTAL ADS	1080			

FACEBOOK ADVERTISEMENTS IN SENIOR'S GROUPS

GROUPS	Approved Posts
27	14
TOTAL ADS	14

Appendix D: Letter of Information (LOI)

Impacts of COVID

19 Physical Distancing on Women Experiencing Intimate Partner Violence at Home

Online Survey and Interview

Research Team:

Tara Mantler, PhD, Assistant Professor, Western University (PI)

Kimberley T. Jackson, RN, PhD, Assistant Professor, Western University

Jennifer Irwin, PhD, Professor, Western University

Christina Safar, BHSc, incoming MSc, Western University

LETTER OF INFORMATION

Introduction

You are invited to participate in a survey, with the option for an interview that look at the impacts of COVID-19, especially physical distancing, on women who have experienced intimate partner violence. You are being asked to participate because you indicated in a screening assessment that you have experienced intimate partner violence, are 50 years of age or older, and have access to a safe computer/telephone.

Purpose of the study

The aims of this study are to examine the evolving impacts of COVID-19 physical distancing on the lives of women who experience intimate partner violence. We hope to use this information to identify the goals and needs of women to help create health and social service policies for the eventuality of future pandemics.

Who is eligible to take part?

You can take part if you:

- Identify as a woman
- Are 50+ years old
- Have access to a safe computer and telephone
- Have experienced intimate partner violence in the last 12 months
- Lived with your abuser(s) during COVID-19

If you agree to participate

If you agree to participate you will be asked to set aside approximately 25 minutes to complete an online survey. If you choose to participate in an interview, you will be asked to set aside approximately 45-60 minutes for a telephone/video interview. Consent will be implied by clicking the button "I consent" at the start of the survey. Verbal consent will be audio recorded

at the start of the interview. The survey will consist of questions relating to your demographics, relationships, experiences of abuse and COVID-19, and coping and resilience. The interview will ask about your experiences of intimate partner violence, social support, resilience, and coping before and during COVID-19. You will be provided with a topic list and secure meeting link/number prior to the interview. If you decide to participate in the survey, please confirm at the bottom of this screen and enter a telephone number where we can text you a passcode for the survey. You will have the opportunity to opt-in to an interview at the end of the survey by entering a safe email. Upon completion of the survey, if you opted-in to an interview, you will be emailed a link to set up an interview date and time.

Compensation

There is a \$15 honorarium (Amazon gift-card) to recognize your time and contributions to the interview. You must opt-in to the interview by entering your email in the survey and complete the interview to receive the \$15 honorarium. The \$15 e-gift-card will be emailed to you upon completion of the interview.

Potential Risks & Benefits

The risks of taking part in this study are small. It is possible you may find it distressing to respond to questions about your experiences of violence during COVID-19. There is also the risk that your abuser/partner will see you completing the questionnaire and/or see/overhear you participating in the interview which may put you at increased risk. If either occurs, we encourage you to connect with the Assaulted Women's Helpline at 1-866-863-0511.

By completing this survey, and interview if you choose to participate, you are contributing to our efforts to understand coping and resilience in the time of COVID-19 which may help us to better address violence against women in future pandemics. However, it is possible that you may not directly benefit from participating in this research.

Confidentiality

All information collected for the study will be de-identified. Any electronic data not stored on Western servers will be encrypted. Only members of the research team will have access to the data. All will be destroyed after 7 years.

No information that could identify you will be used in any publication or presentation of study results. If direct quotes are used to highlight certain findings, any potentially identifying information will be removed. Participants will be identified in study results by assigned pseudonyms.

Transcripts and audio files will be saved on a secure password-protected server at Western University. Any electronic data not stored on Western servers will be encrypted, including any de-identified transcripts sent offsite for transcription.

Voluntary Participation

Participation in this study is completely voluntary. If you feel hesitant or uncomfortable answering some questions, you can refuse to answer those specific questions or end the survey and/or interview at any time. You may choose to withdraw from the study at any time prior to the completion of data analysis, and all your data will be destroyed if you wish. You can withdraw your data by emailing [REDACTED] and asking that your data be removed.

Questions about the Study

If you have any questions regarding this study or would like additional information to assist you in reaching a decision about participation, please contact Dr. Tara Mantler

[REDACTED]

If you have any concerns about the conduct of this study or your rights as a research participant, please contact The Office of Human Research Ethics, Western University:

Phone:

[REDACTED]

Appendix E: Verbal Consent

VERBAL CONSENT FORM

Study Name: Impacts of COVID-19 Physical Distancing on Women Experiencing Intimate Partner Violence at Home (interview)

Principal Investigator: Dr. Tara Mantler

Co-investigators:

Jennifer Irwin, PhD, Professor, Western University

Kimberley T. Jackson, RN, PhD, Assistant Professor, Western University

Jennifer Irwin, PhD, Professor, Western University

Christina Safar, BHSc, incoming MSc, Western University

You will be asked to verbally respond to the following questions at the beginning of your interview:

Have you read the letter of information and had any questions about the study or your participation answered? YES NO

Do you agree to participate? YES NO

Do you agree to be audio-recorded? YES

Do you consent to me taking notes during the interview? YES NO

Do you consent to the use of unidentified quotes obtained during the study in the dissemination of this research? YES NO

Do you consent to a follow up phone call, if I have additional questions after data analysis? YES NO

Participant Name

[To be completed by researcher]

I have explained the study to the participant named above and answered all questions. The participant provided the above responses verbally.

Your Name (please print)

Signature

Date

Appendix F: Safety Protocol

Thank you so much for taking the time for this interview today. I want you to know that there is no right or wrong answer, we are simply interested in what is true for you. If, you for whatever reason need to terminate the interview, you can either hang up the phone or you can start to talk about the weather. If you start speaking about the weather, I will know that it is no longer safe for you to conduct the interview and I can either stay on the line until it is safe, or we can end the call.

Would you prefer I stay on the line or end the call? _____

Appendix G: Demographic Survey

What is your Gender?
What is your current age in years?
What is the highest certificate, diploma or degree that you have completed?
Do you identify as indigenous to Canada?
What is your ethnicity?
What is your sexual identity?
What is your marital status?
What was your employment status before COVID?
What was your employment status during COVID?
Were you an essential worker?
What is your average household income before COVID? (after taxes)
What was your average monthly income before COVID?
What was your monthly income during COVID?
What describes the type of community you live in? Population of where you live
Do you have children?
What is the age of your children?
What is the gender of your children?
What is the living situation of the children? (alone, full-time with you, part time)
What is your living situation? (alone, with children, with partner, both)
Did you practice physical distancing?
What physical distancing activities did you practice? (stayed over 2 m away, did not leave for essentials, left only for essentials, wore a mask, isolated after travel, other)

Curriculum Vitae

CHRISTINA SAFAR

EDUCATION

Master of Science, Health Promotion Current
Western University, London, ON

- Focus: Ageing, intimate partner violence, experience and impact over a long period of time within the
- Courses: Introduction to Research Methods, Health Promotion, Current Topics in Health and Ageing, Current Topics in Health Promotion

Bachelor of Health Science, Honors Specialization in Health and Aging June 2020
Western University, London, ON

- Studied the impact of ageing and the age-related changes on the quality of life and health
- Worked on a cross-Atlantic project comparing health care systems and how they care for their ageing population, presented findings in Norway at the Oslo Metropolitan University

RESEARCH EXPERIENCE

Research Assistant Sept 2020 – Present
Women's Health Matters Research (WHMR) Lab, Western University

- Collaborated with other researchers in the Research Ethics application, the study design, and the data collection process of studies
- Conducted literature searches in health and social science databases, assisted with synthesizing findings and summaries to support findings
- Worked on the thematic analysis of data collected and created and adapted codes as a result of multiple rounds of analysis

Student Researcher Jan – May 2018
Faculty of Health Sciences, Western University

- Collaborative research with 4 Western Health Sciences students and 5 students from Computer Sciences and Physiotherapy programs at Oslo Metropolitan University in Norway
- Conducted informant interviews and a literature review to analyze Canadian and Norwegian approaches to senior immigrant health care integration
- Clearly articulate a summary of our findings after analyzing the collected information, described public health implications, and proposed solutions for more streamlined health administration in Canada and better community supports in Norway

- Participated in a 48-hour Health Innovation Challenge, merging technology innovations with prominent, unresolved issues affecting the quality of life of older adults, and presented a pitch for a product that uses artificial intelligence to provide a teaching program for health care providers

TEACHING EXPERIENCE

Teaching Assistant Sept - Dec 2021
School of Health Studies, Western University

- Provided assistance to a professor in the preparation and organization of course content for a third-year course, both in-person and online
- Responsible for grading assignments of 40 students including papers and critical discussions. Facilitated meetings to help students understand the content and provided guidance on improving writing and critical thinking at a university level

Teaching Assistant Sept - Dec 2020
School of Health Studies, Western University

- Assisted in the creating and organization of online course content delivery for a second-year health sciences course
- Responsible for grading and assisting over 100 students in an online format including the creation of examinations, managing discussion boards and providing students with assistance in improving the quality of students' work.

Tutoring Sept 2020 - June 2021
Private, London ON

- Worked alongside high school students in providing clarity and understanding for topics and subjects the students struggled with
- Provided teaching material to simplify content and advised on structure and delivery of assignments, provided instructions and assistance on preparing for examinations

ACADEMIC PUBLICATIONS & PRESENTATION

Safar, C., Irwin, J., Jackson, K. T., Mantler, T. (Abstract accepted November 2021). Understanding Coping Strategies in Older Women who have Experienced Intimate Partner Violence. Nursing Network on Violence Against Women International Conference. Durham, North Carolina, USA, June 21-23, 2022. Podium Presentation.