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Intimate Partner Violence in Late Life: A Review of the Empirical Literature

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Abstract

This integrated review of the empirical literature synthesizes a decade of scientific research across scholarly and professional publications addressing intimate partner violence (IPV) in late life. Deriving insights through a qualitative coding scheme and detailed analysis of 57 empirical sources, we discuss the theoretical frameworks, conceptual themes, and methodological approaches that cut across the literature. Based on these findings, we identify future research directions for improved understanding of late-life IPV as well as implications for policy development and refined community interventions.

Keywords

domestic violence; elder abuse; older women; spousal abuse

Intimate partner violence (IPV), which includes physical, sexual, and psychological abuse, is a major public health concern (U.S. Department of Health & Human Services, 2000). For most reported cases of IPV, women are the victims and men are the perpetrators. Although reports of IPV decrease as the age of victims increase (Rennison, 2001), the problem does not dissipate. Of the 7.5 million IPV victimizations against women identified by the National Crime Victimization Survey between 1993 and 1999, 118,000 (2%) were committed against women aged 55 or older (Rennison & Rand, 2003). Data from the Women's Health Initiative showed that for women aged 50 to 79, the majority of whom were married, 2% experienced physical abuse and 10% reported verbal abuse in the year prior to the study (Mouton et al., 2004). For persons above age 60, data from a national survey of Adult Protective Services (APS) revealed that in the 10 states that track partner violence, approximately 11% of the substantiated reports of abuse of persons with a known perpetrator involved a spouse or intimate partner (Teaster, Dugar, et al., 2006).

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The National Social Life, Health and Aging Project (Laumann, Leitsch, & Waite, 2008) was the first population-based, nationally representative study to ask community-dwelling older adults aged 57 to 85 (M = 68.0; SD = 0.19) about their experience with mistreatment. Of the 9.0% of 3,005 respondents who reported verbal mistreatment in the 12 months prior to the study, 26.2% identified a spouse or romantic partner as the perpetrator, and of the 2.0% who reported physical mistreatment, 19.6% identified a spouse or romantic partner as the person responsible. A second national study of 5,777 adults ranging in age from 60 to 97 (M = 71.5; SD = 8.1) revealed a similar 1-year pattern for the prevalence of emotional (4.6%) and physical (1.6%) mistreatment among community residing elderly respondents (Acierno et al., 2010). Although published reports of this study have yet to address IPV specifically, older women who experienced physical mistreatment were more likely than older men to live with the perpetrator (80% vs. 47%) and to be physically mistreated by a relative (84% vs. 41%) (Amstadter et al., 2011). With the aging of the Baby Boom generation, the incidence and prevalence of IPV in late life are expected to increase.

Although scholars and practitioners who address elder abuse (EA) or domestic violence (DV) recognize that IPV occurs in late life, there is not a cohesive and easily identified body of literature informing this issue. This is, in part, because older women often are invisible in scholarly investigations of DV, and IPV in late life is regularly overlooked in studies of EA (Brandl, 1997; Penhale, 2005). Desmarais and Reeves (2007) noted that the incidence of IPV among elders has been obscured by its inclusion under the broad umbrella of EA, which does not resonate with DV advocates and gives disproportionate amounts of attention to abuse perpetrated by adult children and caregivers, as opposed to intimate partners. Similarly, Straka and Montminy (2006) observed that DV research and intervention typically is “grounded in a gender perspective but does not account for age,” whereas the EA literature is often “grounded in an aging perspective but does not account for gender” (p. 253). Older women, they concluded, “are located at the intersection of these two dimensions of age and gender” (p. 253).

In this article, we present an analysis of a decade of empirical literature on violence in late life to further understanding of IPV and identify potential frameworks for advancing research and developing IPV intervention strategies for older adults. Although previous reviews provided valuable insights for particular service sectors such as health care (Fulmer, Guadagno, & Bolton, 2004; Hightower, 2004), law enforcement (Desmarais & Reeves, 2007; R. J. Koenig & DeGuerre, 2005), and DV victim advocacy (Penhale, 2005), to our knowledge no attempt has been made to systematically assemble and integrate scientific findings across the literature.

Method

We approached our search of the academic and professional literature (i.e., government or policy center reports) on IPV in late life by predefining search terms and strategies. We used 10 primary terms to search multidisciplinary electronic databases that index scientific journals, web-based resources, and professional reports: *intimate partner violence, IPV, domestic violence, spouse/spousal abuse, violence against women, elder abuse, domestic elder abuse, same sex partner violence/abuse, lesbian partner violence/abuse, homosexual*

partner violence/abuse. These terms were systematically entered, often in conjunction with *elderly, aging*, and *older adults* to keep the focus on later life, in the following five databases: *AARP Ageline, SAGE Full-text Collections from CSA, EBSCOhost* (selected databases: gender/sexuality, health sciences, law/political science and psychology/sociology), *Ingenta-IngentaConnect*, and *Family and Society Studies Worldwide from NISC*. We used EndNoteX4©, an electronic reference management system, to organize the documents. Through this process, we identified 366 original sources that included 125 empirical investigations, 27 review articles, and 51 professional reports published from 1999 to 2009. Each source gave specific attention to IPV in late life, either as a primary focus or as a secondary topic.

Coding and Analysis

The coding scheme emerged as articles were located. We first organized the literature by defining each emergent area to ensure consistency in classification. As the coding process unfolded, we redefined and refined the codes and reclassified entries accordingly. Each document was initially coded by primary topic area. A second round of coding expanded the codes to include secondary topics. When appropriate, entries received multiple codes (e.g., policy and law enforcement, racial, ethnic, or cultural diversity, and multidisciplinary response could be coded for one article), which enabled us to identify which aspects of late-life violence received the most attention within each article and across the literature. Approximately 25% of the entries were coded by two of the co-authors to establish interrater agreement. All of the articles were coded by the second author. Verification was done independently by the third author, who reviewed the article in its entirety without knowledge of its original codes. All authors discussed discrepancies in coding to reach full agreement. This intensive coding approach yielded 100% agreement in the development and application of the coding scheme, which enhanced the rigor of the analysis and the dependability of the findings (Anfara, Brown, & Mangione, 2002).

Based on primary and secondary rounds of coding, the 366 articles were grouped into 15 topic areas: practices and programs ($n = 95$); health outcomes and interventions ($n = 77$); policy and law enforcement ($n = 73$); screening, assessment, and referral ($n = 58$); vulnerability and risk ($n = 54$); prevalence and incidence ($n = 53$); geographic, racial, ethnic, or cultural diversity ($n = 47$); dynamics of abuse ($n = 36$); prevention ($n = 31$); gender comparisons ($n = 26$); multidisciplinary team response ($n = 26$); behavioral health ($n = 24$); coping behavior ($n = 21$); perceptions ($n = 16$); and homicide and homicide/suicide ($n = 10$). For this review, we focused on 57 of the 125 empirical investigations that presented findings specifically about IPV among persons aged 50 and older. Articles were excluded if “age” was presented such that findings specific to older adults could not be identified (e.g., sample ranged in age from 30 to 60) or were not discussed.

In presenting our findings, we selected specific articles as representative examples of the empirical studies found in the literature, not necessarily as superior research on IPV in late life. For a complete citation listing of the 57 articles analyzed, including a description of key features of each of the articles (i.e., theory use, methodology, sample characteristics, and salient findings), go to http://www.gerontology.vt.edu/research.html

Findings

Our analyses identified three domains that cut across the empirical literature: (a) theoretical frameworks, (b) conceptual themes, and (c) methodological approaches. Overall, much of the research lacked a theoretical framework from which to understand older adults' experiences with IPV and their interactions with the formal service sector, focused primarily on White women aged 50 and older, included only descriptive analyses of the data, and was embedded in larger studies of elder mistreatment.

Theory Use and Integration

The authors of only 9 of the 57 articles explicitly identified a guiding theory or underlying theoretical framework for their research. The two most common frameworks identified were feminist theories of power and control (e.g., Hightower, Smith, & Hightower, 2006) and ecological approaches (e.g., Teaster, Roberto, & Dugar, 2006). Other theoretical frameworks applied in two studies were a lifespan perspective (Band-Winterstein & Eisikovits, 2009) and social representation theory (Montminy, 2005). Examining IPV from a lifespan perspective brings attention to the long-term and cumulative effects of violence in the lives of older adults, whereas social representation theory focuses on how individuals' perceptions and behaviors are influenced by how they see and understand violence in their relationships. A fifth framework, a Risk Model for Elder Mistreatment, was described as a "theoretical sketch" within which to organize national EA policy and health-related research efforts (Daly, Hartz, Stromquist, Peek-Asa, & Jogerst, 2008). This model focuses on characteristics of the victim, the perpetrator, and the victim-perpetrator relationship and interactions. The use of language referring to the "embedded" nature of these foci in physical, social, psychological, and socio-cultural context suggested that this model also has origins in ecological theory. In 11 additional articles, the use of theory was implicit. Nine of these studies were guided by principles of feminist theory, one used a combination of lifespan and ecological concepts, and one applied a life course perspective.

In addition to these 20 investigations, the authors of 3 studies relied on a grounded theory approach to formulate theoretical constructs to explain IPV. From their analyses, the authors develop substantive theories to describe, explain, and understand how older persons characterize relational tensions and conflicts that precipitated the violence (Lowenstein & Ron, 1999; Ron & Lowenstein, 1999) and made sense of their situation (Zink, Jacobson, Pabst, Regan, & Fisher, 2006).

Feminist theories.—Scholars relied predominantly on feminist theory to clarify the dynamics of IPV across the lifespan, address age, and gender inequalities, and discuss resultant service gaps (e.g., Harbison, 2008; Hightower et al., 2006; T. S. Koenig, Rinfrette, & Lutz, 2006). Inquiries overwhelmingly suggested that examining IPV through a feminist lens provided a more accurate depiction of violent relationships over the life course and challenged the adequacy of a caregiver stress model often used to explain late-life IPV dynamics (e.g., Chrichton, Bond, Harvey, & Ristock, 1999; Klein, Tobin, Salomon, & Dubois, 2008; T. S. Koenig et al., 2006; Lev-Wiesel & Kleinberg, 2002). For example, Hightower and colleagues (2006) found that older women often reported abuse by multiple

partners throughout their lifetimes and some women described abuse by husbands over the course of decades with an increase in controlling behaviors exhibited after their husbands retired.

Other scholars found that the power dynamics within abusive intimate relationships throughout adulthood tend to persist in late life, even after male perpetrators become sick and frail and were recipients of care from the partners they had abused (e.g., T. S. Koenig et al., 2006; Lev-Wiesel & Kleinberg, 2002). An analysis of drawings depicting battered wives' perceptions of their spousal relationships revealed that even when husbands were incapacitated by late-life illnesses, the women's drawings did not reflect their changed objective circumstances; male abusers were still depicted as large, standing over women, and exhibiting threatening postures (Lev-Wiesel & Kleinberg, 2002). Findings from interviews with women who experienced psychological abuse suggest that controlling behaviors exhibited by their male partners actually increased as the men's health declined (Montminy, 2005). T. S. Koenig and colleagues (2006) also suggested that the established power dynamics between intimate partners often persist long after the perpetrators become weakened by illness or disability and the victims enter into caregiving roles. For some couples, physical violence continued even as the perpetrator's health declined (Band-Winterstein & Eisikovits, 2009). These findings illuminate the need for more comprehensive theoretical frameworks that simultaneously address the power and control dynamics that typically characterize gender-based violence and the caregiving arrangements and exchanges that may complicate interactions among intimate partners in late life. Such insights can inform practitioners as they help victims address the ethical dilemmas posed by their dual identities as victims and caregivers and identify resources that can help them manage their situations.

Harbison (2008) also used a critical feminist lens in her analysis of interviews with informal service providers in Canada to explore tensions between the DV shelter movement (designed to meet younger women's needs and desires to leave abusive relationships) and the predominant desires of older women to manage their abusive situations without leaving their homes. Providers indicated that older women articulated numerous realistic concerns about leaving their current situations and did not perceive the availability of viable long-term supports necessary to leave their abusive relationships. Harbison suggested that ageism is a silent barrier to service provision and argued that the needs of older women have been ignored because of inaccurate assumptions about their desire for privacy and inability to adapt. Moreover, she contended that some advocates view older victims as threatening the progress of the shelter movement because of their reluctance to leave abusive relationships. She asserted that ageism within the service sector must be directly confronted if providers want to effectively address the diverse needs of older victims and provide them with viable options to escape violence.

Hightower and colleagues (2006) applied a feminist lens to empower older women to share their life histories of violent relationships, perceptions of the service sector, and unique service needs. Data collected from a province-wide campaign echoed the findings of other studies; many older women suffered abuse in various forms throughout their lives, and "the impacts of leaving a relationship in later life are associated with various problems and risks

that are not present or are not the same for younger women" (p. 219). Yet, interviews also revealed that older women had the same basic needs as younger women for a safe environment, emotional support, advocacy, information, and peer support. The application of a feminist perspective and empowerment approach to data collection in this study helped show the complexity of layered emotional, health, and situational factors in late life, and the diverging and converging needs of older and younger women, providing important insights for implementing interventions for older women in violent relationships.

Ecological perspectives.—Authors also frequently applied or arrived at findings that suggested the integration of an ecological perspective (Bronfenbrenner, 1986): An approach that addresses the individual, familial, societal, and ideological layers that interact over time in the lives of IPV victims. The basic premise of this approach is that experiences with violence are embedded within and cannot be fully understood without consideration of the context of family, community, and societal environments (Bonomi, Anderson, Rivara, & Thompson, 2007). This perspective takes into account informal personal or familial relationships, the formal support of agencies or service providers, and the broader ideological norms, values, institutional patterns that influence the life experiences of older women (Teaster, Roberto, et al., 2006), and the passage of time (Winterstein & Eisikovitz, 2005).

Using an ecological approach furthered understanding of late-life IPV scenarios and provided guidance for the development of intervention programs. For example, Winterstein and Eisikovitz' (2005) qualitative analysis of in-depth interviews with 21 battered women aged 60 to 85 found that women's experiences of loneliness permeated each ecological level. They suggested that the cumulative experiences women have with personal relationships across the lifespan "color their emotional lives with a sense of separateness, social and psychological distance from others, and lack of continuity in their life stories" (p. 15). After finding pronounced adverse physical and mental health effects associated with the lifetime sexual violence of women aged 18 to 64, Bonomi, Anderson, Rivara, and colleagues (2007) asserted that because symptoms of a lifetime of sexual violence can present as general physical ailments or depressive symptoms, practitioners need to take into account the ecological layers that contribute to an overall health profile and make universal screening for sexual IPV part of a patient's diagnostic process.

Teaster, Roberto, and Dugar (2006) also demonstrated that the ecological framework can improve understanding of how unique community factors, such as those of a rural setting, can shape abuse experiences and service utilization patterns of late-life IPV victims. Through focus groups with service providers and interviews with older women, they identified how common IPV service barriers in rural areas are compounded by age, how familiarity between service providers and victims can interfere with effective IPV response, and how government policies in rural areas can obscure the issue of DV in late life. From their examination of the layers of context, which ranged from the personal perspectives of IPV victims to the broader ideological values predominant in a region of rural Kentucky, the researchers identified education, prevention, and intervention needs unique to late-life IPV scenarios in rural areas.

Conceptual Themes

Although there are gaps regarding how scholars have approached understanding of IPV in late life theoretically, we found four dominant conceptual areas addressed across the literature. These four themes—late-life patterns of violence, coping with violent relationships, negative health outcomes, and critical response strategies—were addressed in three-fourths of the articles.

Late-life patterns of violence.—Although the prevalence of physical and sexual violence declines in late life (Rennison, 2001; Rennison & Rand, 2003), the research shows a persistent presence of non-physical IPV in late life. Some authors suggested that this type of violence may even increase in frequency or severity as partners aged and non-physical violence dissipated (e.g., Daly et al., 2008; Fisher & Regan, 2006; Lundy & Grossman, 2004; Mezey, Post, & Maxwell, 2002). For example, using the Conflict Tactics Scale to measure self-reported domestic partner violence among 362 older partners in a rural Iowa county, Daly and colleagues (2008) found that 32% of the respondents reported emotional abuse, whereas only 2% reported physical abuse. Fisher and Regan's (2006) findings from telephone interviews with 842 community-dwelling women aged 60 and older also showed that emotional or psychological abuse occurred at a much higher rate among study participants than any other type of abuse. Approximately 45% of the respondents indicated that they had experienced emotional abuse since age 55 compared with only 4% who reported physical abuse and 3% who had experienced sexual abuse.

Other authors also noted that a shift from physical to non-physical forms of violence dominated late-life scenarios. According to prevalence and incidence data on individuals aged 65 and older served by DV agencies across Illinois between 1990 and 1995, 95.9% of the respondents reported experiencing emotional abuse. Physical abuse was experienced by 71% of the older adults, whereas only 4.9% reported sexual violence (Lundy & Grossman, 2004). Based on secondary analysis of data from the Michigan Violence against Women Survey, Mezey and colleagues (2002) concluded that by expanding the definition of IPV to include different types of psychological abuse, IPV prevalence rates among older women were similar to those of younger cohorts. Zink, Jacobson, Regan, Fisher, and Pabst (2006) emphasized the profound cumulative effects of psychological violence over the course of older women's lives. They found that for older IPV victims, "psychological abuse continued and even escalated" throughout their relationships, suggesting that the later years may be "a period of increased psychological vulnerability for elderly partnered women" (p. 858).

Coping with IPV in late life.—In addition to a different landscape of abuse experiences, older women also exhibit different coping styles and strategies than younger victims of IPV, who may have more flexibility financially, socially, and psychologically to leave abusive situations (Beaulaurier, Seff, Newman, & Dunlop, 2006; Hightower et al., 2006; Ron & Lowenstein, 1999; Zink, Regan, Jacobson, & Pabst, 2003). Based on analysis of data from 21 focus groups that explored the perspectives of middle-aged and older women on DV, Beaulaurier and colleagues (2006) concluded,

> For many middle-aged and older women, leaving may not be an option. It seems reasonable to speculate that many older women in need of help for domestic

> violence may not even consider seeking help if they believe that separation is necessary … Respondents indicated that for many women of their generation treatment must be within the context of their marriages to be viable. (p. 70)

Findings from Hightower and colleagues' (2006) survey of older women who experienced IPV also suggested that the financial and emotional risks of leaving a relationship in late life, while similar to those for younger women, are amplified by increased likelihood of financial dependence, deep social ties to neighborhoods, and strong sentimental attachments to place (e.g., home, community).

Physiological changes associated with age or declining health, as well as early negative experiences reaching out for help, also influenced older women's choices to stay and cope within the physical parameters of their current relationships (Zink et al., 2003). Harbison (2008) noted that societal norms and local culture often shape older women's identities, making efforts to change or leave the relationship more difficult with the passage of time. Because family privacy and traditional gender roles within marriage are highly valued by many older women and may conflict with the feminist ideals driving many DV service models (Harbison, 2008), older survivors often are reluctant to access services because of implicit disapproval of their coping choices by service providers.

Some DV programs addressed the issue of conflict between the shelter system and the needs of older clients by offering support groups specifically for older victims of IPV who choose to maintain their relationships with their abusers (Brandl, Herbert, Rozwadowski, & Spangler, 2003). Group facilitators not only reported major benefits for participants in these programs (e.g., emotional support, a break from isolation, information about resources) but also noted challenges initiating and maintaining these groups.

Negative health outcomes.—Eleven of the 57 articles analyzed for this review focused on health outcomes related to IPV, including 10 large-scale quantitative studies and 1 in-depth qualitative project. All investigators reached similar conclusions: Involvement in violent relationships was associated with negative health outcomes for survivors of IPV.

Responses from a random sample telephone survey with 2,876 women aged 18 to 64 who received health services through a Group Health Cooperative in Washington State and Idaho indicated that women who had experienced either physical or sexual IPV, or a combination of both types of abuse, suffered higher rates of adverse mental, social, and physical health outcomes as compared with women who had never been abused (Bonomi, Anderson, Rivara, et al., 2007). In a similar study focused explicitly on the lifetime prevalence and health-related consequences of IPV in the lives of women aged 60 and older, Fritsch, Tarima, Caldwell, & Beaven (2005) found that 93% of the 933 respondents experienced psychological stress and 73% suffered physical injuries as a result of IPV. Findings from a clinical study of 842 community-dwelling women aged 60 and older designed to identify the long-term health effects of IPV suggested that women who experienced psychological/emotional abuse one time, repeatedly, or in combination with other types of abuse had significantly increased odds of reporting bone or joint problems, digestive problems, depression or anxiety, chronic pain, and high blood pressure or heart

problems (Fisher & Regan, 2006). Based on data from urban health clinics, Sormanti and colleagues also established that women aged 50 and older experiencing IPV were at a higher risk for HIV than women of the same age who had not experienced IPV in the past 2 years (Sormanti & Shibusawa, 2008; Sormanti, Wu, & El-Bassel, 2004). Risk factors for HIV included having a partner who insisted on intercourse without a condom, having intercourse with a suspected or known IV drug user, and having a sexually transmitted infection.

Because IPV studies have focused almost entirely on female victims, health outcomes for male victims are not well-understood (Reeves, Desmarais, Nicholls, & Douglas, 2007). Indeed, men were sampled in only one of the empirical studies focusing on health outcomes. Findings from this retrospective telephone-based cohort study with men enrolled in an integrated health system were similar to those of older women; older men who were victims of IPV were more likely to have poor mental health outcomes than older men who had not experienced IPV (Reid et al., 2008).

Critical response strategies.—Scholars across disciplines concurred that community-wide education campaigns, primary prevention efforts, and interdisciplinary collaboration and cross-training are essential components in an effective response to IPV in late life (e.g., Dunlop, Rothman, Condon, Hebert, & Martinez, 2001; Leisy, Kupstas, & Cooper, 2009; Teaster, Roberto, et al., 2006). Yet, despite this consensus, we found few articles that identified specific models or strategies for systematically integrating and evaluating prevention and intervention responses for older persons experiencing IPV. We suspect, however, that our lack of access to data regarding the success or failure of community programs might also stem from bias in many scholarly journals against publishing small, site-specific program evaluations.

We found only one report of a program evaluation among the identified empirical articles. In this study, Brownell and Heiser (2006) used an experimental design to test the impact of an elder mistreatment psycho-social support group intervention for older women experiencing family and IPV. The authors reported no change in, or differences in measurable outcomes for, control and intervention groups. However, all but one participant in the support group perceived improvements in their self-esteem and feelings of well-being. The researchers suggested that the small number of participants ($n = 16$) and use of outcome measures that may not have been sensitive enough to capture change may account for the apparent lack of intervention effectiveness. Despite the marked limitations of this study, the findings bring attention to the importance of evaluating program effectiveness.

Methodological Approaches and Challenges

Approaches to studying IPV in late life included quantitative ($n = 27$), qualitative ($n = 22$), and mixed-method ($n = 7$) designs. Data collection methods included personal interviews, case reviews, surveys, focus groups, and the analysis of secondary data. Study participants included community-dwelling older women, perpetrators, care providers, physicians, social workers, and other service professionals.

Quantitative investigations.—Large-scale quantitative investigations of IPV in late life focused predominantly on prevalence and incidence ($n = 15$) or health outcomes and

interventions (n = 9). Several research teams, in fact, dealt simultaneously with these topics (n = 6). Bonomi and colleagues (Bonomi, Anderson, Reid, et al., 2007; Bonomi, Anderson, Rivara, et al., 2007) analyzed survey data collected from enrollees in a group health cooperative that addressed prevalence, types, duration, frequency, and severity of IPV against older women, as well as health outcomes for women with exposure to IPV. Similarly, Mouton and colleagues used clinical data to examine the interrelationship between late-life IPV and health outcomes (Mouton, 2003; Mouton, Rovi, Furniss, & Lasser, 1999). As elaborated more fully in other sections of this article, the findings of these studies supplied important information about lifetime and recent exposure to different types of IPV and the adverse mental and physical outcomes of this exposure.

Other quantitative investigations focused on a range of topics including IPV vulnerability and risk, concerns of practice and programming, community setting (rural vs. urban), and issues of racial, ethnic, or cultural diversity. Chrichton and colleagues (1999), for example, used case reports of incidents of DV involving older adults to examine risk factors specific to gender and age. Another research team surveyed DV program coordinators across British Columbia and the Yukon to determine service gaps and programming needs of victims of DV, aged 50 and older (Hightower, Smith, Ward-Hall, & Hightower, 2000). Grossman and Lundy (2003) used statewide data from Illinois to compare the experiences and needs of White, African American, and Hispanic female victims of abuse (aged 55+) who sought services from DV programs. In one of the largest studies identified in the empirical literature, Dimah and Dimah (2003) analyzed data from the Illinois Elder Abuse and Neglect Program to identify differences in family violence experiences of rural (n = 7,178) versus urban (n = 7,614) women. These and other quantitative investigations (e.g., Daly et al., 2008; Jasinski & Dietz, 2004; Kim & Sung, 2003; Klein et al., 2008) provide crucial data regarding late-life IPV prevalence, incidence, and outcomes within health system and DV service sector client populations. Quantitative studies have yet to explore on a large scale, however, the prevailing experiences and patterns of IPV among the vast number of older adult victims and perpetrators who may shun formal medical care or may never come to the direct attention of service providers. Capturing the scope and outcomes of these “unseen” cases of abuse remains a serious challenge. Mears (2003) discussed the importance of mining these untapped experiences in the context of her qualitative work:

> The research clearly demonstrates the importance of sharing stories … this is empowering for female victims of IPV … despite the difficulties and the shame, older women will speak up about the violence in their lives if they are given a safe space and an opportunity to do so and if they can expect to be believed. (p. 1488)

Qualitative studies.—Using a variety of qualitative approaches, several scholars illuminated the perspectives of older IPV victims. For instance, Beaulaurier and colleagues (2006) conducted focus groups with 134 middle-aged and older women. They identified several barriers to seeking help among older female victims of IPV (e.g., self-blame, hopelessness, the need to protect family). They also discovered that the women were quite open and interested in sharing their experiences in a group setting with women roughly their own age, who had also experienced DV, but with whom they had no previous social connection. Other qualitative inquiries have led to equally important insights that

inform understanding of older victims and their abusers, including how self-concept and life circumstances intersect in the lives of older women in the process of breaking away from violent partners (Buchbinder & Winterstein, 2004), unique service needs of older victims of IPV (Hightower et al., 2006), co-occurring health problems of abused older women (Zink, Jacobson, Regan, & Pabst, 2004), coping methods used by older female victims of IPV (Zink, Jacobson, Pabst, et al., 2006), categorization of psychologically violent behaviors displayed by male perpetrators toward their intimate partners (Montminy, 2005), and relationship dynamics between older women and their abusers (Zink, Jacobson, Regan, et al., 2006).

Because many scholars meld research and advocacy, findings from qualitative studies often promoted changes in regional or national policy or practice. For example, the work of Hightower and colleagues (2006) led to a specialized outreach worker training for DV shelter staff to connect with older adult victims. This effort resulted in the initiation of four pilot projects to train staff in DV programs and safe homes used for emergency refuge in British Columbia and the Yukon. Outcomes of these pilots, however, have yet to be reported in the scientific literature.

Secondary data.—Sixteen of the 57 empirical studies relied solely or partially on secondary data. While the utilization of existing data sets provided researchers with large, random, county, or national level samples, there are also inherent limitations to their use. Investigators frequently used data from studies that had not focused specifically on issues of IPV in late life (n = 10 articles; that is, Daly et al., 2008; Jasinski & Dietz, 2004; Mezey et al., 2002; Rennison & Rand, 2003; Shibusawa & Yick, 2007). For their study of self-reported IPV among partners aged 65 and older, Daly and colleagues (2008) relied on data from a population-based prospective study that originally focused on the relationship between environmental and agricultural exposures, injuries, and respiratory disease. The National Violence Against Women Survey (Tjaden & Thoennes, 1998) provided the data for Jasinski and Dietz's (2004) analysis of DV and stalking among 3,622 older adults. In this case, the original study was focused on DV, so items addressing DV and stalking were an integral part of the survey. However, items were not specifically designed to capture the experiences of older adults and, therefore, may not have accessed the same responses as an instrument tailored for a particular age group (e.g., questions sensitive to cohort differences in language, questions specific to late-life experiences).

Secondary analyses of agency reports, case files, and case studies were other methodological approaches found in the literature (e.g., Chrichton et al., 1999; Grossman & Lundy, 2003; T. S. Koenig et al., 2006; Osgood & Manetta, 2002). Although case files offered rich data, and in-depth case reviews were particularly helpful for illustration of practical strategies, relying on this type of data had some inherent pitfalls. For example, Grossman and Lundy (2003) compiled information on 2,702 White, African American, and Hispanic female victims of DV aged 55 and older from the Illinois Coalition Against Domestic Violence central agency reporting system. The data collected were reported by many different agencies from across the state, suggesting that consistent reporting may be difficult to ensure. In addition, there was the issue of timeliness of the information, with the 2003 article reporting on the use of DV services across race and ethnicity for adults aged 55 and older in the years 1990-1995.

Measures and data collection tools.—Another methodological challenge researchers faced was the availability of uniform measures and appropriate data collection tools. Reports of the prevalence of IPV varied depending on the source of information, period of abuse covered, and range of abusive behaviors included in the definition of IPV. For example, using 5 questions from the Behavioral Risk Factor Surveillance System and 10 questions from the Women's Experience with Battering Scale, Bonomi, Anderson, Reid, and colleagues (2007) assessed IPV in the lives of older women based on lifetime exposure (26.5%), past-5-year prevalence (3.5%), and past-year prevalence (2.2%). Responses to 12 questions from the original Conflict Tactics Scale from older cohabitating adults suggested a 2% prevalence of physical violence and a 32% prevalence rate for emotional abuse (Daly et al., 2008). Conversely, Sormanti and Shibusawa (2008) analyzed responses from six items from the Conflicts Tactics Scale, which emphasized not only actual physical and sexual violence but also threats of this violence. They found that 5.5% of the women in their study had experienced some type of actual or threats of physical or sexual violence in the 2 years prior to the study.

Identifying the prevalence of IPV in later life was also challenged by how researchers define late life and the ways in which age was categorized. In two studies, the onset of menopause was considered the beginning of old age (Beaulaurier et al., 2006; Mouton, 2003), whereas other researchers designate the starting point for "late life" abuse at age 55 (e.g., Rennison & Rand, 2003; Zink & Fisher, 2007), age 60 (e.g., Fisher & Regan, 2006; Montminy, 2005), or age 65 (e.g., Daly et al., 2008; Lundy & Grossman, 2004). The consistent use of age demarcations is important, as many scholars (e.g., Rennison, 2001; Wilke & Vinton, 2005; Zink et al., 2003) agreed that women of different age cohorts may (a) experience different rates and types of abuse, (b) live with violence for different amounts of time (affecting the degree of negative health impacts), (c) hold different views regarding how to cope with or disclose violence, and (d) experience an increase in limiting health conditions with advancing age (additional barriers to leaving abusive relationships). Thus, the complexity of intervening variables often associated with chronological age or cohort membership can result in markedly different prevalence rates.

Although there is no "gold standard" screening tool for assessing IPV in late life, many authors echoed the sentiment that screening, assessment, and referral for IPV in late life should be an integral part of health care provision (Ahmad & Lochs, 2002; Brandl & Horan, 2002; Mouton, 2003; Ramspacher, 2002). Unfortunately, the existing research clearly established that screening and referral for older victims of IPV have not been practiced routinely in most medical settings (Bonomi, Anderson, Rivara, et al., 2007; Zink, Jacobson, et al., 2004; Zink, Regan, Goldenhar, Pabst, & Rinto, 2004). For example, interviews with a random sample of women patients aged 65 and older from one health care system serving two western states revealed that although 26.5% of the respondents reported experiencing some type of partner violence, only 3% indicated that they had been asked by a health care provider about physical or sexual violence by an intimate partner since the age of 18 (Bonomi, Anderson, Rivara, et al., 2007).

The limited number of screening tools that focus specifically on violence in late life includes the *Screening Tools and Referral Protocol for Stopping Abuse against Older Ohioans*

(STRP; Bass, Anetzberger, Ejaz, & Nagpaul, 2001). The STRP went through several phases of development, focus-group feedback, and a two-step structured quantitative evaluation process for use in the state of Ohio (Ejaz, Bass, Anetzburger, & Nagpaul, 2001), perhaps establishing a model for future systematic tool development. Although widely distributed and used by Ohio service providers, to our knowledge information regarding the impact of using the STRP on violence reduction or health outcomes has not been published.

Paranjape, Rodriguez, Gaughan, and Kaslow (2009) customized the *Family Violence against Older African American Women* (FVOW) scale to accommodate gender and cultural differences in late life. This tool was developed specifically to measure family violence exposure among older inner-city African American women in clinical settings. Importantly, the scale also distinguishes between abuse stemming from family relationships and abuse associated with a caregiving role.

Future Directions: Advancing Research, Practice, and Policy

Through growing research efforts, the complexities surrounding IPV in late life are being untangled. Researchers and practitioners are in prime positions to advance and influence the study of IPV in late life and, ultimately, the development of effective intervention practices. Thus, we conclude with specific recommendations to further understanding of IPV in late life and addressing the needs of older victims.

Merging Theory and Practice

Although we applaud the integration of theory in IPV research and programs, researchers and practitioners need to make their theoretical assumptions and predictions more explicit. Less than one-half of the studies reviewed were grounded in identifiable theory, and many authors did not incorporate their theoretical framework throughout the presentation of their work. Explicit use and integration of theory will elevate the impact of IPV in late-life research by strengthening the formulation of research questions and hypotheses, improving selection of study variables, and deepening the interpretation of results.

The role of theory in late-life IPV program development often is viewed very differently by academics than community service providers, with practitioners possibly minimizing the importance of theory in service provision, or simply neglecting to recognize the theoretical frameworks underpinning practice (Bergeron, 2002; Payne, 2008). This may be attributed to the failure of researchers to convince practitioners that successful model development and implementation stem from sound theory (Payne, 2008). Or, as Bergeron (2002) suggested, theory can operate incognito. She described how a family preservation framework, although not explicitly applied by elder protection service workers, provided an implicit guide for their decision-making processes. Such frameworks need to be acknowledged more openly in policy directives and program design. Thus, the study of IPV in late life would benefit from more open and ongoing dialogue among researchers, practitioners, and advocates regarding the use of theory and elucidation of the theories already driving existing service models.

Broadening the Research Agenda

To improve the accuracy of prevalence and incidence data, researchers and practitioners across disciplines need to agree on basic operational definitions of IPV, DV, EA, and "older adults." Moreover, a systematic review and assessment of the suitability of existing screening tools, which typically were developed and used in clinical settings with younger women, for use with older victims of IPV need to take place to ensure their utility and reliability in identifying IPV (Nelson, Nygren, McInerny, & Klein, 2004; Paranjape et al., 2009; Phelan, 2007).

The range of violence experienced among older IPV victims suggests that scholars need to examine the precursors and consequences of more than the physical abuse most frequently associated with IPV (e.g., verbal, psychological). Psychological violence is especially difficult for older victims to identify in their own lives, and practitioners often are not prepared to identify or respond to these "unseen acts" of verbal and emotional abuse (Montminy, 2005; Seff, Beaulaurier, & Newman, 2008). As non-physical abuse appears to escalate or intensify in late life as physical and sexual violence declines (Seff et al., 2008), researchers need to pursue deeper understanding of the reasons for, and implications of, this apparent shift in perpetration patterns.

Most investigations of IPV in late life included ethnically homogeneous samples of predominantly White females. Because findings from large-scale studies and needs assessments suggested that patterns of IPV perpetration, coping, and service needs may vary among different ethnic groups (Dunlop et al., 2001; Kim & Sung, 2003; Leisy et al., 2009; Mouton, 2003; Shibusawa & Yick, 2007), in-depth qualitative studies with a broader cultural range of older adults are warranted. Further differentiation between the perspectives of urban and rural residents also merit attention, as abuse experiences, service barriers, and cultural contexts vary considerably in different regions (Dimah & Dimah, 2003; Harbison, 2008; Schaffer, 1999; Teaster, Roberto, et al., 2006).

Women are most frequently identified as victims of IPV, whereas men most often are identified as the perpetrators of the violence. While we recognize that men, as well as same-sex couples, also experience IPV, we found few studies devoted to the exploration of male victim perspectives and no empirical literature on gay or lesbian couples. Although some authors critiqued the gender bias in late-life DV research (Reeves et al., 2007; Reid et al., 2008) and suggested that risk factors associated with IPV (e.g., fear, social isolation, mental or physical impairments) and power dynamics within relationships are intertwined with age and health, none of the investigators explored these issues relative to female-on-male violence in late life. Thus, the intersection of gender with the behaviors and beliefs of victims and perpetrators is an important area for future exploration.

Finally, there is a paucity of longitudinal investigations of IPV, which leave unanswered questions about the ways in which IPV affects the lives of older adults over time. Although Band-Winterstein and Eisikovits (2009) applied a lifespan perspective as they analyzed interviews with older couples experiencing marital violence, they extrapolated their findings from one-time interviews. Interviews with 459 women aged 55 and older revealed that the 13% of women with physical assault histories were more likely to report current symptoms

of depression, substance abuse, and posttraumatic stress disorder than the women who reported no prior physical or sexual assault (Acierno et al., 2007). A cohort analysis of data from the National Violence Against Women Survey revealed that although the nature and consequences of physical abuse were similar for women aged 18 to 29, 30 to 44, and 45 and older, the differences found highlighted particular life circumstances of older victims of IPV (Wilke & Vinton, 2005). Specifically, older women were more likely to remain with their abusers than were the younger women, the duration of the violent relationship was significantly longer for the older women than for the younger women, and older women experienced higher rates of chronic physical and mental health problems than younger women. Thus, the cumulative effects of experiencing IPV at any point in the life cycle on health and psychological well-being in late life warrants further consideration.

Translating Research to Practice

DV and EA researchers, practitioners, and victim advocates have played a paramount role in production of present day knowledge of IPV in late life. Their efforts, however, often occur within professional silos. As IPV in late life gains greater attention, multidisciplinary teams, particularly those that embrace and integrate perspectives of researchers, practitioners, and victims from the onset of service planning through implementation and evaluation (Agency for Healthcare Research and Quality, 2002) are most likely to produce replicable and sustainable programs that meet the needs of older victims of IPV. Moreover, as noted by Mancini, Nelson, Bowen, and Martin (2006), although individuals perpetrate violence, IPV occurs in a community context; thus, responses and solutions must include not only the victims but also the broader environment. Such an understanding will better inform the focus of future research and possible avenues for safe and effective prevention and intervention programs. Because policy is inextricably linked to the creation and fiscal backing of local and national programs addressing aging issues, the exchange of information among stakeholders and policymakers is critical to garner support for the development and implementation of new services and interventions that will nurture and sustain the physical, social, and psychological well-being of older adult victims of IPV.

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