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Violence Against Rural Older Women: Promoting Community Awareness and Action

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Abstract

Objectives—To identify opportunities and challenges in promoting community support for rural older women experiencing intimate partner violence (IPV).

Methods—Using community-based participatory research principles, we engaged in an academic-community partnership to analyze the research literature, estimate IPV incidence and prevalence, ascertain professional and older IPV victim perspectives through focus groups and interviews, and develop a collaborative community response plan. This study took place from 2008 to 2010 in the U.S.

Results—IPV in late life is underreported by victims and often unrecognized by the academic and service community. Professionals, while agreeable to collaborating to support older IPV victims, sought coordination and leadership from domestic violence agencies. Older victims stressed the need for improved professional sensitivity to their unique needs and more service options.

Conclusions—The insights generated during this project produced a framework on which rural communities can build to address the hidden and growing problem of late life IPV.

Keywords

intimate partner violence; older women; community engaged research; community response plan

Introduction

The most pervasive form of violence committed against women around the world is by a husband or intimate male partner; a phenomenon that occurs irrespective of social, economic, religious, or cultural groups [1,2]. Incidents of IPV include physical, sexual, and psychological/emotional harm caused by a current or former partner [3] and often involve verbal and financial abuse as well as a combination of multiple forms of abuse [4,5]. While the focus of research, practice, and policy typically addresses intimate partner violence (IPV) toward young women, U.S. national data suggests that a significant number of middle-aged and older women also experience IPV [6]. Approximately 2–5% of women in the U.S. aged 50 and older are physically abused and 22–32% are psychologically abused by their intimate partners each year [7–10]. Indications of late life violence are worldwide; including in Australia, where 1 in 4 women who report domestic violence are aged 45 or older [11]. Although global age-aggregated data are not available, in 48 population-based

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surveys from around the world, 10–69% of women of all ages reported being physically assaulted by an intimate male partner at some point in their lives, with 3–52% having been assaulted by an intimate partner in the previous 12 months [2]. With the marked aging of the population, the incidence and prevalence of IPV among older women is expected to increase significantly. In this paper, we describe an academic-community partnership created to raise awareness of intimate partner violence in late life and to develop a response plan to meet the needs of older victims in a rural community.

IPV, Aging, and Rural Communities

Older women are less likely than younger women to report abuse, seek help, or use the services provided by an emergency women's shelter [12–14]. Their reluctance to seek services is often deeply rooted in shame and humiliation, fear of further abuse, fear of having to make major lifestyle changes, lack of financial resources to live independently, guilt about abandoning an abuser in poor health, deep convictions about the sanctity of marriage, or the need to keep family problems private [13–15]. While considered potential sources of support, healthcare providers and other community service professionals do not routinely identify victims of abuse. Many lack information about IPV and confidence in identifying signs of abuse, have limited screening tools and few screening protocols in place, deliver services under time constraints, and are generally unaware of community resources available to older victims [13, 16]. Barriers to receiving help are often compounded for older women in rural communities where strong personal ties to the community, a culture of self-sufficiency, patriarchal views of the family, limited community services, isolation, and economic stressors may contribute to and conceal violence in relationships [17, 18]. These and other rural issues, including limited transportation, remote geographic locations, limited program resources, and shortages of healthcare workers challenge human service providers around the world [19].

The World Health Organization has recognized violence against women as an urgent public health priority [1], and this issue is particularly salient among older rural women given the rapid aging of the global population and universal rural health challenges. Because recognition and response to this pressing and largely neglected issue can vary dramatically within community and cultural contexts, it can be approached best at the local level.

Our approach to understanding and responding to late life IPV was based on the assumption that community members share norms that govern behaviors and expectations that determine both licit and illicit activities [20, 21]; activity generally considered unacceptable by society might be more tolerated among certain segments of the population. For example, as a group, residents of rural communities in America often hold strong the values of self-reliance, conservatism, and individualism, as well as traditional attitudes about family and gender roles, and distrust of outsiders [22]. The variation and complexity of rural communities is reflected in the structures, processes, and actions engaged in by their members. One structure, *networks* - both informal and formal - plays a significant role in promoting the physical, psychological, social, and spiritual well-being of community members and families [23]. Different networks often interface and provide support for older women experiencing IPV.

We operated under the premise that although individuals perpetrate violence, IPV occurs in a community context; responses and solutions must include not only the women, but also the broader environment [23]. Project activities focused on older female victims of IPV, the community support available to them (e.g., community-victim services, law enforcement, health care providers, faith community leaders), and the broader ideological values, norms, and institutional patterns of the rural communities in which they lived [18].

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Study Aims

The overall goal of this project was to increase awareness and address gaps in community support that typically characterize rural late life IPV experiences. Specific study aims were to: (1) Identify existing empirical research and programs addressing issues of intimate partner violence among older women; (2) Project the prevalence of older women likely to become victims of IPV in the study area; (3) Obtain the perspectives of community leaders about IPV among older women as well as gather insights from the women themselves; and (4) Develop a community response plan to address the needs of victims of IPV living in rural communities.

Method

During 2008–2010, the Center for Gerontology (CFG) at Virginia Polytechnic Institute and State University collaborated with the Women's Resource Center of the New River Valley (WRC) to address the issue of IPV among older rural women living in rural Virginia, a state located in the southeastern part of the United States. The project team engaged in community-based participatory research (CBPR) practices [24, 25] to address issues facing rural older women who wish to lead safe and violence-free lives and to identify the community support needed to help them successfully rebuild their lives. The project team received regular input and guidance from members of a community advisory group (AG) - New River Valley Task Force on Domestic Violence Among Older Adults - led by the WRC. The AG included 47 members representing victims and community service professionals in law enforcement, healthcare, social services, long-term care, the faith community, and academia.

Study Site

Located in rural southwestern Virginia, the New River Valley (NRV) served as our project site. Nestled in the hills of the Blue Ridge Mountains, residents live in areas with population densities ranging from 36.4 – 215.5 persons per square mile. The total adult population (aged 18+) was approximately 178,000. Nearly 30% of residents were aged 50+; 13% were aged 65+ and 5.5% aged 75+ [26].The racial makeup of the NRV was predominately White (93%). Median household income ranged from $27,585 to $37,241; 14% of residents had incomes below the federal poverty level [27].

Procedures

The project team completed a systematic review of the academic and professional literature on IPV published from 1999–2009 to identify existing intervention models, issues, and outcomes for older women (Study Aim 1). We predefined search terms and strategies to ensure that the review was comprehensive and used 10 primary terms (i.e., intimate partner violence, domestic violence, violence against women, elder abuse) to search five multidisciplinary electronic databases that index scientific journals, web-based resources, and professional reports. The English-based databases searched included *Ageline*, *SAGE Full-text Collections*, *EBSCOhost* (selected databases: gender/sexuality, health sciences, law/political science and psychology/sociology), *Ingenta-IngentaConnect,* and *Family and Society Studies Worldwide*.

To estimate the occurrence of IPV in late life locally, data were collected from representative surveys on violence and local law enforcement agencies (Study Aim 2). Local community service providers (i.e., social services, domestic violence hotline and shelter, emergency health responders) provided estimates of incidences.

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To gain insight into the beliefs about late life IPV held by community service professionals and the strategies they used to respond to this issue, we conducted 12 focus groups with 72 providers who were likely to come in contact with older victims of IPV (M = 6 participants per group). The participants included local members of law enforcement and the criminal justice system, social services directors and supervisors, paraprofessional staff with the local domestic violence program, mental health counselors, primary healthcare providers, emergency healthcare responders including physicians and forensic nurses, home and community-based service providers, clergy and lay clergy, and business and community leaders. Standard focus group methodology was followed [28]. Participants were asked questions to assess their perceptions and beliefs about the prevalence and characteristics of IPV in late life, knowledge about current response services, challenges they faced when responding, collaborations among professions in the community, and the willingness of community professionals to implement a response plan. Each session was tape recorded and later transcribed verbatim by a professional transcriptionist in preparation for coding and analysis. An additional 15 community professionals (e.g., faith leaders and members of law enforcement) who were unable to attend the focus groups were interviewed by telephone. They responded to the same questions posed to the focus group participants.

Individual, in-depth interviews were conducted with 10 women, aged 54 to 70, who lived in the NRV and had experienced IPV within five years of the project. The women were recruited through the shelter operated by the WRC; AG members also helped locate aging women willing to be interviewed. Questions asked of the women focused on the types of violence they had experienced, how the violence affected them, and what community providers and agencies need to know in order to facilitate their safety and assist them in rebuilding their lives without violence. Interviews lasted approximately 90 minutes and were tape recorded, transcribed verbatim, and verified by the research team for accuracy prior to coding and analysis.

To develop a community response plan to address the needs of aging victims of IPV living in the NRV (Study Aim 4), project team members lead a full-day workshop to create preliminary models based on the findings generated from data collected for study Aims 1–3. Attendees included members of the project's AG, key community members and professionals, the NRV Elder Abuse Coalition, and the Sexual Violence Coordinating Councils in each of the five localities within the NRV.

Results

Knowledge Development

We identified 57 key empirical investigations that presented findings specifically about IPV among persons aged 50 and older [29]. Among these investigations, IPV in late life was often presented as a piece of a larger study on domestic violence or elder abuse and rarely examined on its own. As a result, most studies lacked a theoretical framework from which to understand older adults' experiences with IPV and their interactions with formal service providers. Although there were gaps in how scholars approached understanding IPV in late life, four topics dominated the literature: patterns of violence in late life, coping with violent relationships, negative health outcomes, and critical response strategies. As understanding of IPV increases and levels of awareness rise in communities, researchers, practitioners, and victims will need to work together to produce replicable and sustainable programs that provide victims with the help they need. A complete listing and summary of the of the 57 articles can be found at http://www.gerontology.vt.edu/resources.html.

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Prevalence/Incidence of IPV

In light of the fact that older women rarely report abuse to the authorities [3], statistics on the prevalence and incidence of IPV in late life were challenging to estimate. Domestic violence data are not specific to violence in later life and elder abuse statistics often do not specify abuse by a spouse or intimate partner. Comparative analysis indicated that the aggregated incidences reported locally generally coincided with national-level estimates. During the same calendar year, 6% of calls to local police that involved adults ages 50 and older were incidents of IPV; 11% of calls to the WRC crisis line were from older victims of IPV; and 15% of the residents housed in the WRC emergency shelter were older women. Most community professionals working with the project team agreed that more victims of IPV kept their victimization hidden than reported it.

Perspectives of Community Professionals and Older Women

Community professionals—Key findings from the focus groups were that participants had limited awareness about IPV in late life and had not particularly given much thought to it as a problem in their communities. As focus group discussions unfolded it became increasingly clear to the participants that many shared inaccurate preconceived notions about IPV in late life that were based on ageist attitudes (e.g., old people are not violent) and stereotyped victims as being young, White women living in poverty. As conversations progressed, group members also realized that they had limited knowledge about local services available to victims of IPV in late life or held inaccurate assumptions about who was helping them (i.e., doctors, clergy, and domestic violence shelters). Yet, despite having limited awareness of the problem and how community professionals respond, participants perceived that their communities would respond collectively to address the issue if it was identified as a significant problem in their area. Participants suggested that by circulating prevalence data, awareness could be raised, although few people were able to identify sources for that information. Participants also expressed a willingness to collaborate with other professionals to help resolve a situation, but expressed concern that client confidentiality would need to be addressed.

Older victims of IPV—The women interviewed shared similar health and social support profiles, but represented a diverse range of relationship experiences, educational attainment and professional backgrounds. Most of the women experienced family violence early in their lives and found themselves engaged in violence across many intimate relationships, continuing the cycles of violence into their adult relationships. One woman, for example, experienced emotional, physical and sexual violence first perpetrated by her foster father and then within four different marriages over 70 years. She stated “I've always been looking for someone to care about me and treat me the way I treated them, but I just haven't found them; seems like I'm always picking the wrong ones”.

Predominantly, the women also resisted seeking help until they perceived the violence was life threatening. Even occasions of being chased after with a knife or threats of gun violence were not enough to motivate women to seek help. One woman reached-out for the very first time at age 59, after 35 years in an abusive marriage. When asked why she had not told anyone about her constant terror before that day, she said, “I was ashamed. I just didn't want to admit that's the situation I was in.”

Similar to community professionals, the women highlighted the need for improved community-wide education and awareness about IPV in late life. The women placed more emphasis, however, on the need for discreet information made readily available to victims in public venues, improved professional sensitivity to the needs of victims under duress, and more enhanced, diverse, long-term shelter and housing options for older women. One

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women who had accessed local domestic violence services and was living completely on her own for the first time in her 61 years of life, wanted more follow-up support through calls, support groups, or home visits. Although relieved to be living a life free of violence after two prolonged abusive marriages, she worried constantly about "health issues and what will happen if something happens to me…who will I contact…my finances, things like that…It's scary".

Community Response Plan

During a planning workshop led by the director of the WRC, members of the project team provided the group with information gathered during project activities (i.e., common themes of literature, prevalence estimates, gaps in services identified through focus groups, priorities of victim interviewees) to facilitate identifying ideas regarding response plan components. The planning process was guided by a three-tiered goal framework: 1) short-range goals that could be accomplished with one year; 2) medium-range goals that required some additional resources and/or prerequisite steps prior to implementation; and 3) long-range goals that required significant restructuring and/or increased resources. Three distinct types of activities emerged within each time-sensitive goal: (1) direct services to victims, (2) capacity building activities within the WRC, and (3) interprofessional responses within the community. The final community response plan, with action steps identified for each target area, is shown in Table 1.

Since codifying the community response plan, community partners have addressed several of the short-term goals encompassed in this plan.

Educational materials—With input from the AG, information gathered during the project was used to develop a series of five educational brochures on IPV in late life and a companion slideshow presentation for use by community professionals and educators. Additionally, a brochure about IPV in late life was developed specifically for older women who may be victims of IPV. These resources are available at http://www.gerontology.vt.edu/resources.html.

Community outreach—This project generated a "buzz" among community professionals about the issue of IPV in late life, and a shared enthusiasm emerged for current and anticipated projects. At the WRC, employees have increased outreach among older adults by distributing informational materials on IPV at public events and community health fairs. They have also received external funding to develop training on IPV in late life for telephone volunteers serving "senior to senior" hours and to provide a series of informational sessions on IPV to members of the local faith community. To achieve long-term response plan goals, additional funding is being sought to support a permanent staff position to direct services of older adults served by the WRC and to further academic-community collaborations targeting the needs of older victims of IPV.

Discussion and Conclusion

As noted by Mears [30 p23], "Violence against older women can no longer be left in the *too hard* basket. It is clear there is an urgent need to reframe social policy to take account of the needs of older women…the problem must be taken seriously at all levels of policy making and service delivery". Our local collaborative effort and resultant action plan have already strengthened response to late life IPV at individual, service, and systemic levels. We are confident that the community connections formed, the insights gained from victims and community members, and the community response ideas generated during this project will also continue to sustain local dialogue about issues related to IPV in late life. Moreover, the

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work completed has produced a framework upon which our community, and others around the world, can build upon to cope with this hidden and growing problem.

One challenge of implementing community-engaged CBPR projects is motivating all community partners to take full ownership and involve themselves in every aspect of the project. Although we made every attempt to involve CFG and WRC leadership equally in all aspects of the project, some steps were more easily accomplished by the CFG (Aims 1 & 2), or led by skills unique to the WRC staff (Aim 3 – interviews with victims of IPV). Likewise, ownership in the project and participation in project activities among AG members was affected by professional constraints on their time and thus fluctuated throughout the project. These patterns of intermittent participation are expected to continue and may ultimately extend the time needed to complete future goals. Moreover, although the action steps suggested for capacity building were developed with input from community professionals and stakeholders, leadership in their respective agencies may or may not identify these actions as priorities for their organizations.

Although there is much diversity across rural areas, the rural community involved in this project mirrored, at least in part, the general characterization of rural America -- geographic isolation, economic strains, strong social and cultural norms, and limited social services – which significantly compound the problems confronted by older women seeking support and services to end abuse. Based on the existing literature, we have no reason to believe that the issues of violence for older women in the NRV are different from other rural areas. We advocate for additional research to examine further individual and community characteristics and dynamics that influence the manifestation of violence in the lives of rural older women and the ways in which the health, service, faith, justice, and other formal networks perceive and respond to the women's situations and needs.

By sharing our experiences, we hope to stimulate thought about the transferability of our project to other communities, both rural and urban, across the globe. The approach, leadership structure, and aims of the project can easily be adjusted to address the local culture, population, resources, and service needs of the particular geographic area. With IPV among older women emerging as a pivotal health issue, each community's successes and lessons can be built upon to improve world-wide response to this mounting health concern.

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Key Points

- IPV in late life is a hidden problem that is underreported by victims and unrecognized by most community professionals.
- Community professionals are agreeable to working together to support victims of IPV in late life.
- Community professionals rely on local domestic violence agencies for leadership and support in developing a coordinated and sustainable community response plan.

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Table1

Key Components of the Community Response Plan

Areas of Need	Action Steps		
	Short-term	**Mid-term**	**Long-term**
Direct Services	• Add additional resources for older adults to WRC Information and Referral system • Distribute newly developed education material about IPV in late life to older adult groups and victims	• Provide a support group at the WRC specifically for older adult victims • Offer senior-to-senior hotline hours, when older trained volunteers would staff the WRC hotline • Fund WRC staff member to serve as a liaison with other community agencies serving older adults	• Provide transportation services to and from appointments and groups for older adults • Fund a full-time WRC staff member to coordinate programs/service and outreach specific to older adult victims • Provide IPV counseling and advocacy services in community and home settings when safe and appropriate
WRC Programs	• Provide awareness presentations to older adult groups in the community	• Develop safety planning materials specific to the needs of older adult victims • Target volunteer recruitment efforts and train volunteers to respond to older adult callers • Expand trainings on screening to more medical professionals in our community	• Remodel shelter to create a room or suite for older victims that is private and quiet • Develop a multi-disciplinary intervention team to work with victims who must or choose to remain in their homes • Develop contracts and funding for assisted living facilities and long-term care facilities to provide emergency and/or longer-term shelter for victims
NRV Community	• Improve communication of information related to suspicions of IPV between agency programs • Display educational and awareness materials on IPV in prominent and accessible places in agencies serving older adults	• Institutionalize training on IPV into orientation for direct service providers • Develop a collaborative service agreement for multi-agency cooperation in complex cases involving older adults experiencing IPV	• Develop IPV prevention education for youth on healthy relationships • Fund a full-time staff member at the Agency on Aging as a specialist, advocate and liaison for IPV victims • Establish regional elder abuse multidisciplinary team to staff complex cases involving IPV