Domestic violence victims in later life: Older women and intimate partner abuse (IPV)

Las mujeres mayores y el maltrato por parte de sus parejas

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ABSTRACT

Domestic violence is a social problem framed by both gerontologists and feminists in the 1970s. Old age is defined as 60 years of age and older and this can be a time of vigor and renewal as well as a time of frailty and decline. Domestic violence against older women is defined as physical, sexual, financial, neglect and abandonment. Quantitative research has examined prevalence of abuse affecting older women, and qualitative research captures the stories of intimate partner and family abuse in older women’s own words. Together findings help shape interventions designed to promote women's safety and well-being in old age. An overview of definitions, theoretical frameworks, research, and interventions including programs for older women victims of intimate partner and family abuse is provided using case examples as illustrations.

KEY WORDS

Older women, Domestic violence, Intimate partner abuse, Elder abuse, Elder abuse interventions, Elder abuse research

RESUMEN

La violencia doméstica es un problema social enmarcado tanto por gerontólogos como feministas en los años 70. La etapa de la vejez se establece a partir de los 60 o más años y puede ser una etapa de vigor y renovación, así como de fragilidad y declive. La violencia doméstica contra las mujeres mayores es definida como física, sexual, económica, negligencia y abandono. La investigación cuantitativa ha examinado la prevalencia del maltrato hacia las mujeres mayores y, la investigación cualitativa se centra en las historias de violencia en las propias palabras de las mujeres mayores. Ambos tipos de investigación ayudan en la elaboración de intervenciones diseñadas para promover la seguridad y el bienestar de las mujeres mayores. En este artículo se revisan las definiciones, marcos teóricos, investigación e intervención, incluyendo programas para mujeres mayores víctimas de violencia doméstica.

PALABRAS CLAVE

Mujeres mayores, violencia doméstica, violencia infligida por la pareja, maltrato a mayores, intervenciones, investigación
• Maria, age 76, has been married for 40 years to her second husband, Franco. He verbally abused her in the beginning of their marriage but now he is suffering from Alzheimer’s Disease and he has begun to hit her when she is providing care to him. She feels she cannot leave him because he married her when she was a single mother with a young son who was abandoned by his father, and adopted her son. Now an adult, her son is estranged from her and Franco because of Franco’s behavior toward her, for which he blames her.

• Juana, age 80, is divorced and lives with her nephew, Roberto, the son of her diseased sister. Roberto suffers from bipolar disease and is a substance abuser. Juana feels she cannot ask Roberto to leave because she promised her sister before she died that she would care for him. Roberto does errands for Juana, styles her hair, and is kind to her when he is feeling well; however he is abusive when he is drinking or not taking his medication. Recently Juana called the police when Roberto hit her, but was so upset by their rough treatment of him during the arrest that she refused to testify against him. She subsequently let him back into her home, where he continues to behave erratically toward her, and she continues to support him financially.

• Portia, age 69, lives with her husband, Eduardo, a prominent architect and a civic leader. She has been physically and emotionally abused by him for over 40 years, during which time he has also had many affairs with other women. She has tried to leave him several times, but he refuses to discuss a divorce and will not give her money to live apart from him. Portia was trained as a nurse before she was married but has no money of her own.

Elder abuse was first defined as a significant social issue in the 1970’s in the USA as a form of domestic violence that affects care dependent elderly victims and is perpetrated by caregivers, often adult daughters (Steinmetz, 1988). Unlike abuse of women of reproductive age, in the 1970’s, domestic violence against the elderly was framed by the professional community as a medical and social problem. Recommended interventions included mandatory reporting of elder abuse, adult protective services in the community, screening in
emergency rooms, hospitals and nursing homes, caregiver support groups for the caregivers presumed to be at risk of developing caregiver stress, a presumed risk factor for abusive behavior, respite programs, and legislation to criminalize endangering vulnerable adults. Research on elder abuse in this paradigm found that victims were most likely to be older white women in their 80’s and their adult daughter caregivers (Brownell, 1998).

Advocates for the elderly and for women soon realized that while important as it is to ensure protection of frail care dependent elderly at risk of abuse in their homes or care facilities, this approach was overlooking many older women who were not care dependent and lived independently, but who were in long term abusive relationships and/or were supporting care dependent abusive loved ones (Bergeron, 2001). This profile of victim/abuser dyad looked more like that of battered women of reproductive age. However, the difference was that older women experiencing abuse were past reproductive age and in some cases struggling with issues related to aging, and the abuse included not only intimate partner violence but also abuse by adult children and other relatives (Brandl & Cook-Daniels, 2002).

The age at which a victim is identified as an older woman is related to the paradigm of abuse under discussion (Leisley & Cooper, 2009). Old age in the domestic violence (DV) and intimate partner violence (IPV) framework may begin as early as 50 years, in community samples, 60 years, and in medical settings, 65 years of age and older (WHO, 2008). Elder abuse is defined as "a single or repeated act or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person" (WHO, 2008, p. 6).

**THEORETICAL FRAMEWORKS**

Early studies of elder mistreatment suggested that care dependent older women were most likely to be abused by overwhelmed caregivers, most notably adult daughters (Steinmetz, 1988). Other studies, in particular a large scale prevalence study conducted in Boston (USA), challenged these findings and suggested that caregiving older adults were most a risk of abuse by impaired adult relatives for whom they were providing care (Pillemer & Finkelhor, 1988).
More recently, studies of older women and domestic violence note similarities in dynamics of abuse for women of all ages (Raymond & Brandl, 2008). Power and control dynamics are used to explain the cause of abuse of older women by perpetrators of all ages (Brandl, 2000). Some studies diverge from this frame in explaining abuse of caregiving older women by impaired spouses with dementia like Alzheimer’s Disease (Paveza, 2010).

Critical feminist gerontology is a framework used to conceptualize research that reflects women’s own experience of growing older as well as the social construction of values related to women’s old age (Freixas, Luque & Reina, 2012). Practice implications of this theoretical perspective for older women and IPV in the US have been examined by Vinton (1999) and for older women suffering from neglect in Sweden by Jönson & Åkerström (2004).

Prevalence of IPV and Older Women: Cross National Comparisons

While overall prevalence of domestic violence involving older women victims is lacking, some studies have begun to gather data on this. Some prevalence studies have been conducted in the USA and in the European Union (EU). In a recent USA study reported in the Gerontologist (Bonomi, Anderson, Reid, Carrell, Fishman, Rivira & Thompson, 2007), lifetime partner prevalence rate for women age 65 and above is 26.5%, with 18.4% women experiencing physical or sexual violence, and 21.9% experiencing non-physical abuse. In this study, past five year prevalence is 3.5% and past year prevalence is 2.2%. Prevalence differs based on sampling criteria, including whether old age is defined as beginning at 50 years, 60 years or 65 years (Fisher, Zink & Regan, 2010).

One of the most ambitious recent prevalence studies on IPV and older women includes the European Union DAPHNE study (Montoya, 2011). In contrast to the findings of the US prevalence study referenced above, overall abuse reported by older Portuguese women age 60 and above is 39.4%, with 32.9% reported emotional abuse, 16.5% reported financial abuse, 12.8% violation of rights, 9.9% neglect, 3.6% sexual abuse and 2.8% physical abuse (Ferreira-Alves & Santos, 2011).
In a study of German older women and abuse, the lifetime prevalence of physical and sexual partner violence is 23% among women 50-65, and 10% among women 66-86 years of age (Stöckl, Watts & Penhale, 2012). Data are limited for older women in Asian cultures including Chinese older intimate partner violence survivors in North America, due to cultural reticence and definitional issues according to Shibusawa & Yick (2007).

Existing prevalence data on older women and domestic violence suggests that age cohort and cultural factors can influence findings. However, existing data also demonstrate that the problem of DV and older women is significant, especially if viewed from a life course perspective.

**FINDINGS FROM QUALITATIVE RESEARCH: IN THEIR OWN VOICES - OLDER WOMEN AND VIOLENCE**

In addition to prevalence studies on DV and older women, feminist researchers have begun to give voice to older women in sharing their experiences of violence (Mears, 2002; Penhale, 1999). One purpose is to give women the opportunity to speak up about violence. Another is to bring the hidden problem of violence against older women to the fore, in order to educate and influence policy makers, convince organizations serving battered women that they have a role to play in combating domestic violence against older women as well as those of reproductive age, and ultimately to reduce violence of all kinds experienced by older women (Mears, 2002).

Sexism and ageism have been identified as barriers to understanding the central themes and dilemmas of older women DV victims. Bergeron (2001) suggests that such constructions as older battered women being defined as elder abuse victims shape policy and practice as well as legal approaches that do not respond adequately to the problem of late life domestic violence. Recent studies on older battered women by qualitative researchers (Smith, 2012; Buchbinder & Winterstein, 2003) demonstrate the salience of adult children and the ambivalence older women struggle with in attempting to resolve life choices in the face of DV and IPV.
Paradigms of abuse from research on older women and domestic violence are varied, taking into account the more complex family and life situations of older women compared with younger women of reproductive age. In addition to class, race/ethnicity and cultural differences, older women’s health due to age related changes may fluctuate, with vision and mobility issues more prominent in older women compared with younger women. Older battered women may also suffer from undiagnosed depression, a not uncommon mental health issue that may be related to the aging process (Berman & Furst, 2010) as well as adverse life experiences.

Most significantly, the relationships between older women victims of abuse and their abusers are more varied than reported by younger battered women. Abusers may include spouses and partners, some of whom may be experiencing age related illnesses like Alzheimer's Disease or frailty due to heart disease, as examples. They may also be impaired or unimpaired adult children and grandchildren, dependent younger grandchildren, and other family relatives. Older women victims may be providing caregiving and other support to some of these abusive partners and family members. Understanding the profiles of abuse and experiences of DV and IPV from older women victims' experience is essential for a full understanding of needed interventions and services that can lead to their safety and increased quality of life (Dakin & Pearlmutter, 2009).

Recommendations for interventions have emerged from qualitative research on older women victims of IPV and domestic violence (Mears, 2002). They can be divided into four categories: surviving with violence, getting help, leaving the violence, and achieving independence and empowerment. Surviving with violence coping strategies include blocking out memories of violence, self-medicating, escaping into a fantasy world, and channeling energy into other activities such as reading, going to school, and work. Getting help includes reaching out and divulging secrets, with the fear of being rebuffed - especially because of age - as a key impediment. Leaving the violence is seen as contingent upon identifying available resources either within the family or in the community. Finally, achieving empowerment and independence is viewed as a necessary final step to achieving a life free of violence. Developing and sustaining support networks, particularly with other women, is identified as essential to this, and includes sharing experiences and having experiences validated (Mears, 2002).
BARRIERS TO HELP-SEEKING AMONG OLDER WOMEN VICTIMS OF ABUSE

While help-seeking is identified as a critical step that older battered women need to take in order to move toward and achieve a violence-free life, there are significant internal and external barriers to taking this step (Beaulaurier, Seff & Newman, 2008). Internal barriers are identified as self-perception of powerlessness, self-blame, felt need to keep abuse a secret, need to protect family members such as children by keeping family intact, protecting income and resources, fear of not being believed, and fear of rejection by children and other family members (Buchbinder and Winterstein, 2003). Finally, there are expressed fears that the batterer is sick and needs help from the older woman victim. The internal barriers cited appeared to override concerns about personal safety.

External barriers include fears about family response, concerns that clergy will not be supportive, and apprehension that law enforcement and the courts will not provide needed assistance and by not adequately protecting the victim after her disclosure of abuse, will expose her to more violence. Victims also feel that community resources for domestic violence are only available to younger women with dependent children, a perception that can be reinforced by lack of responsiveness to the plight of older women victims (Beaulaurier et al., 2008).

Abuser tactics or behaviors can also create barriers to older women victims leaving a violent situation (Beaulaurier et al., 2008). These tactics include isolating the victim from extended family and friends, intimidating the older woman victim by threatening to harm her family members and pets, interrupting phone conversations, and limiting the victim’s contact with others.

Impairment of the abuser is considered a risk factor for abuse in later life among women (Pillemer & Suitor, 1991). As noted above, older women victims identify concerns about the health of their spouse/partner abuser as both a rationale for their abusive behavior and the victim’s inability to leave the abusive situation.

When the abuser is a mentally impaired adult child who is dependent on the older victim for support, this dilemma becomes even more acute. Narrative analysis allows discovery of the lived conflicts
parents providing caregiving of impaired and abusive adult children in later live, and provides a life course perspective on these struggles, sometimes defined as ambivalence Smith, 2012).

**INTERVENTIONS FOR OLDER WOMEN VICTIMS OF FAMILY ABUSE**

Understanding ambivalence as both a sociological and a psychological construct for older adults can provide clinicians working with families with elderly caregivers and impaired adults children a framework for helping older women parents sort through their conflicts and stay safe (Smith, 2012). Effective clinical services for older women experiencing abuse by spouse/partners have been found to include ensuring that victims feel welcome and engaged, letting victims tell their stories, and assisting in the process of empowerment (Tetterton & Farnsworth, 2010). Clinicians should be knowledgeable about services in the community for addressing safety concerns as well.

Older women who provide caregiving to spouse/partners with progressive dementia like Alzheimer’s Disease may find themselves at risk of physical harm from the impaired partner (Paveza, 2010). Studies on the dangers of caring for older adults with Alzheimer’s Disease have identified communication failures as triggers for abusive behavior toward caregivers. Training older caregivers on how to communicate more effectively with their loved ones with Alzheimer’s Disease and other forms of dementia has been found to be effective in eliminating or reducing aggressive behavior toward caregivers, most of whom are older women family members (Paveza, 2010). In situations like this, as well as other examples of family abuse against older women, prosecution has not been found to be a strong deterrent against further mistreatment (Roberto, Teaster & Duke, 2004).

Support groups for older women struggling with IPV are important resources (Brownell & Heiser, 2006; Raymond & Brandl, 2008; Brownell & Lataillade, unpublished manuscript). According to Kaye (1995), support groups are considered crucial in providing a buffer against the negative consequences of aging. Cited benefits of support groups for older women victims of family mistreatment include mutual feedback, empowerment, assistance with coping strategies, and social support (Podnieks, 1999).
Social support provided by groups for older women struggling with DV and IPV is considered especially important in view of tactics used by their abusers to socially isolate them (Brandl et al., 2003). Key issues in planning support groups include timing of group meetings (holding group sessions when older women are likely to be able to attend), providing transportation and food, ensuring freedom to leave the group, and funding. Confidentiality and safety have been identified as important considerations as well; underlying assumptions of support groups with DV and IPV victims in later life address power and control as an underlying motive in the abusive treatment unless proven otherwise (Brandl et al., 2003).

IPV support group models can range from peer led groups without set topic agendas to those centering around activities like sewing, quilt making or art with discussions about abuse secondary, to professionally led groups with structured learning content. One psycho-educational support group model that has been evaluated for effectiveness was developed for a battered women's shelter (Schmuland, 1995), and tested in the community (Brownell & Heiser, 2006). The 8-session group covered the following topic areas: overview of domestic violence in later life; abuse and neglect of older women; the legacy of troubled families; family history and its link to abuse; enhancing self-esteem; depression, anxiety, substance abuse and gambling; coping with loss and change in relationships with loved ones; and services and interventions. Pre-and post evaluations, using a control and intervention group, examined changes in social supports, depression and anxiety, substance use and abuse, locus of control and self-esteem. While findings didn't show significant changes in measures used, participant self-surveys stated strong positive feelings about the group experience. Strengths of the evaluation were that it used a control group and standardized instruments; small sample size was one limitation and the necessary bias in favor of older women participants with minimal cognitive, physical and psychiatric impairments was another (Ploeg et al., 2009).

Empowerment support groups represent another intervention model that has been developed for older women victims of abuse (Brownell & Lataillade, Unpublished Manuscript). The Women’s Empowerment in Later Life (WELL) is another group intervention model developed by Schmuland (1995) and evaluated in the community (Brownell & Lataillade, Unpublished Manuscript).
The WELL program is a psycho-educational support group model designed to educate and prepare elder abuse survivors to be peer counselors for other women experiencing elder abuse, public speaking for community outreach, educating the public on elder abuse, and becoming advocates with legislative officials to influence government policies (Schmuland, 1995).

The support group curriculum was adapted from the Nova House, Selkirk, Manitoba, Canada Facilitator’s Manual (Schmuland, 1995). The curriculum included content on the goals of peer counseling (session one); ethical considerations in peer counseling (session two); leadership training for peer counselors (session three); facilitating small group discussions (session four); enhancing communication skills (session five); active listening (session 6); assertive behaviors (session 7); giving and receiving criticism (session 8); public speaking (session 9); and public advocacy (session 10).

The study included 12 participants. The group was facilitated by two trainers, a licensed clinical social worker, and a graduate student of social work. Participants were asked to attend a 10 week, 2 hour per week, training program, held at the office of the Jewish Association for Services to the Aged (JASA), located in New York, USA. Participants were paid a stipend of $20 for each session they attended. They also received transportation to and from the sessions and refreshments at each session. At the end of the study, participants were invited to become peer counselors, public speakers, and or legislative advocates. Three graduates volunteered to speak at an elder abuse survivors' panel at an elder abuse conference held at a local university and one graduate was the closing keynote speaker for the conference. A fifth graduate joined a senior action organization that promoted legislative action for and by older adults.

At the end of the study, participants were asked to participate in a focus group to discuss their experiences with the study and the extent to which they felt the study intervention achieved its goal. The study goal was to encourage and increase participant’s self-esteem, peer empowerment, and change at the legislative level, as well as to decrease elder abuse by building the capacity of older people to be empowered (Brownell & Lataillade, Unpublished Manuscript).

Most of the participants reported after attending the sessions they felt confident about their ability to share their personal experience with their peers about elder abuse and know when to share.
information with professionals if someone needed help. All participants reported they had gained interpersonal skills on how to relate to their peers and use the highest ethical degree by maintaining confidentiality, not using position of peer counselor for personal gain or power over others, and giving positive feedback. Although participants felt they were well equipped to serve as peer counselors, most expressed interest in joining a group that advocated with legislative offices. It appeared that many of the participants felt more empowered operating as a group rather than as individuals (Brownell & Lataillade, Unpublished Manuscript).

Battered women’s shelter programs have not always been successful for older battered women. This is because of limited resources that have led to prioritizing shelter beds for younger battered women and their dependent children, as well as a general lack of fit between shelter programs and the needs of older women victims (Vinton, 1998; Vinton, Altholz & Lobell-Boesch, 2008).

Outreach and education of providers in service systems like aging service networks including senior centers and adult protective service systems are also considered critical to effective utilization of shelter services by older women.

Most domestic violence shelters were found not to offer special programs for older women (Vinton, 1998). Very few shelters have been developed in long term care facilities (Reingold, 2006), due to expense and lack of reimbursement by government and other funders. A shelter in a long term care facility can accommodate older women victims of abuse who are also physically or cognitively impaired, but may have limited appeal for unimpaired victims.

**DISCUSSION OF CASE EXAMPLES**

Reviewing the case examples in the beginning of this article, it is possible to see what interventions may be useful in addressing the abuse. For Maria, one question is whether the abuse she is experiencing from Franco is related to power and control (Brandl, 2000) or Franco’s impairment due to Alzheimer's Disease. An intervention like an educational support program for caregivers of Alzheimer's patients may also help Maria understand how to communicate with Franco to
avoid triggers to lashing out behavior that may be due to behavioral disinhibitions associated with second stage Alzheimer's Disease (Paveza, 2010).

For Juana, therapy with a psychiatrist as well as a support group for older battered women may be helpful in her moving toward safety. Having an opportunity to explore the roots of her ambivalence about her nephew, in view of her promise to her sister that she would look after Roberto when her sister died, could help her decide how much she really wanted to risk her safety and well-being to honor her sister's memory. The support group could help her realize that she was not alone in struggling with the abusive behavior of her dependent impaired family member.

Portia reflects the profile of a traditional battered woman: she is financially dependent on a wealthy husband with considerable prestige and stature in the community, and he refuses to divorce her. Portia's efforts to escape her abusive marriage are met with considerable external barriers, ranging from lack of availability of legal services for older battered women, lack of domestic violence shelter facilities and lack of counseling and other support services in her community. However, she has education and nursing skills; what she needs is transitional housing and work opportunity with an option to upgrade her skills. Portia was fortunate in that she was able to find a program for older battered women that was able to provide her with these needed services. She has been unable to obtain pro-bono legal services to assist with her divorce proceedings but hopes to save money from her new nursing job so that she can afford to pay for this on her own. The supportive housing she obtained is for older adults and is below market rent, which helps her manage on her own. She is unable to afford to live in the luxury she is used to with her husband, but she values her new life free of abuse and is receiving supportive counseling from the elder abuse program in the community.

Each of the women profiled above are benefiting from increased awareness that older battered women have unique life problems but all benefit from expanded services for older women victims of abuse.

**CONCLUSION**
There is a growing awareness of older women victims of family mistreatment both in terms of prevalence and in terms of commonalities and differences when compared to younger battered women. Both quantitative and qualitative research studies have begun to identify salient factors in cultural differences, age related needs, and service needs and gaps for older women victims. Feminist scholarship has begun to examine the application of frameworks for practicing effectively with older women who are victims of abuse. It is critical that this continue in view of the aging of the world’s population, which will result in proportionally more older women and the potential for more abuse.

Clearly, more research is needed to better understand the prevalence of domestic violence including intimate partner abuse at the intersection of age and gender for older women. In addition, qualitative research is needed to develop a clearer picture of need from an older women victim’s perspective, particularly in culturally diverse communities and developing nations where this social issue has not been examined as yet. In addition to a feminist frame, in light of a growing concern about human rights and older persons, viewing abuse of older women from a human rights perspective is also important (United Nations, 2010)

Finally, there is a need for more empirically based research on program effectiveness for different populations of older women victims of domestic violence, including intimate partner violence. If research and advocacy are going to lead to a demand for more resources and services to meet the needs of older women victims of DV and IPV, there needs to be evidence for the effectiveness of proposed interventions in preventing and eliminating violence. This is the challenge moving forward.

**WOMEN AND ABUSE REFERENCES**


