Older Women and Domestic Violence in Scotland

update 2008

Marsha Scott

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Executive Summary

Updating Older Women and Domestic Violence in Scotland

This report provides an update on literature published since an earlier research project, Older Women and Domestic Violence in Scotland, conducted in 2003-2004 and published in June 2004. The original project was commissioned by Health Scotland and carried out by a team from the Centre for Research on Families and Relationships (CRFR). Since the conference, CRFR has been supported by Health Scotland to engage in a number of dissemination activities, including collaboration with Scottish Women's Aid and the Scottish Executive on trainings and seminars.

Key points

1. Older women are more visible on the domestic violence research agenda now than four years ago. Much of the recent research has been quantitative investigations of prevalence among older women, but an encouraging number of qualitative studies have also emerged.

2. Some of the key issues raised by the original project appeared again in the recent literature: prevalence, the effects of long-term exposure to trauma, the roles of dependency and shame, barriers to service and the conflation of domestic violence with elder abuse.

3. Other issues explored more fully in the newer research include: health outcomes of domestic violence in older women, cohort effects and new service provision models.

4. Evidence indicates that older women in need of services are more likely to be living with their abusers, and experience psychological/emotional abuse at high rates, than younger women.

6. Several recent studies offer interesting perspectives on service development and redesign to better meet the needs of older women, particularly those who do not leave their abusers. Appropriate interventions to address the impact of non-physical violence are also needed.

7. Review of the newer literature reveals a paucity of studies that focus on perpetrators, a significant gap. Also problematic are the varying definitions of domestic violence and older women used across the studies.

Introduction

". . . and for 39 years I got on with it." Older Women and Domestic Violence in Scotland presented findings from research carried out in 2003-2004 and published in June 2004. The research, commissioned by Health Scotland, was carried out by the authors of the report: Marsha Scott, Linda McKie, Sarah Morton, Elizabeth Seddon, and Fran Wasoff of the Centre for Research on Families and Relationships (CRFR). This research turned out to be just the beginnings of a collaborative initiative—first between Health Scotland and CRFR and later to include Scottish Women's Aid and the Scottish Executive—to make older women's experiences visible to the public, their voices heard by policy makers, and their needs reflected in service provision.

From Scottish Women's Aid: a case study in collaboration

While recognising that domestic abuse can and does affect women of all ages, Scottish Women's Aid (SWA) acknowledged the findings of the original research—that there was 'a lack of specific visibility for older women in terms of policy focus and representations of the issue.' The research was a catalyst for work to rectify the situation.

Since the publication of the research, SWA has worked with CRFR to develop and deliver a one day training course addressing older women's experiences of domestic abuse, aimed at service providers working with older women in health and social care settings. This has run successfully in several areas of Scotland and is now mainstreamed through SWA's annual multi-disciplinary training calendar. The collaboration has resulted in a synthesis of research with feminist service provision and expert training, producing a true fusion of theory and practice, research and performance. The work has brought the voices of older women to a wider practitioner audience and underlines the importance of and benefits of 'cutting across turf lines'.

As the project extended into its fourth and then fifth years, we identified the need for an updated review of the literature. This report (and the seminar to discuss it) resulted, and we are grateful for the support from the Scottish Executive that made it possible. In addition, the project itself would have foundered long ago without the insight, flexibility, and unflagging support provided by Fiona Borrowman at Health Scotland and the clever management and creativity delivered by Sarah Morton and her colleagues at CRFR.

Dissemination

From the project's beginning, both CRFR and Health Scotland were committed to putting the research to good use, and activities were designed to get the findings into the hands of policy makers and service providers. Dissemination and development of user and trainer materials have continued since the conference launching the work in June 2004.

Effective dissemination required, among other things, mainstreaming of findings into training of service providers in the violence against women sector. Scottish Women's Aid (SWA) has long been the largest and most effective provider of training on domestic violence in Scotland, and CRFR was therefore delighted to enter into a collaboration with SWA to integrate older women's issues into SWA's training. (See commentary in box.)

The update

This review reports on literature published between 2003 and 2007 and reflects a "scanning of the horizon" rather than a systematic literature review—as Fran Wasoff said about the original review, this review is selective and indicative rather than comprehensive and conclusive. The search strategy identified work by key authors and publications from the original review as well as articles identified using the usual key words.

The size of the pool of relevant articles was a happy surprise—older women are far more visible on the research agenda than when we first looked at the literature in 2002-03. Even more encouraging is the fact that, although they are still faint, the voices of older

women survivors can be heard in a number of qualitative studies that highlight women's stories (see, for example, Zink *et al*. 2006).

A substantial number of the articles reviewed here report on quantitative research into prevalence in the population of older women. The findings reiterate earlier data indicating that older women experience domestic violence in significant numbers, although the studies reflect a dizzying variety of definitions of domestic violence and of older (ranging from 45+ to 65+).

Analysis of the literature rested on two themes:

1. Findings related to key themes from our previous research
2. Findings that could or should inform policy and service design

Some of the key issues raised in the original research also feature in the recent literature—defining prevalence, the effects of long-term exposure to trauma, the roles of dependency and shame, barriers to service, and the conflation of domestic violence in older women with elder abuse are the main examples. Health outcomes of domestic violence in older women, cohort effects, and new service provision recommendations are reflected in some of the newer findings.

I Prevalence and profiles

Much of the new literature reported on efforts to define prevalence of domestic violence in older women. The research in this area—mostly from the United States—offers some interesting new insights but suffers from widely varying assumptions and definitions and theoretical frameworks that lack a consistent gender analysis.

The invisible perpetrator

Much of the research fails to gather data on or even to identify perpetrators. The gap was noted by a number of researchers. Comments included, "We were unable to find any published study that examined IPV [intimate partner violence] perpetrators in older women. Therefore only the elder abuse literature is available for comparison" (Zink *et al*. 2005, 884) and "to our knowledge, no study has examined profiles of the older abuser" (Zink *et al*. 2006, 852).

The missing perpetrator may be a cause and/or a consequence of the conflation of elder abuse and domestic violence, which is no less a feature of the current literature than it was four years ago. For example, a 2006 article in *Practice Nurse* titled "Domestic violence and abuse: elder abuse" never mentions domestic violence and has only the following reference to gender:

> *The AEA [Action on Elder Abuse] analysis showed that women were three times more likely than men to call the helpline... .Gender seems to be relevant to the type of abuse. AEA found that older men were more likely to report neglect or financial abuse, while older women were more likely to complain of physical and psychological types... .Traditional gender roles may have an impact. Consider, for instance, how a man may find it easier to report he has been a victim of financial abuse rather than say he has been called names or ridiculed. (Harris 2006)*

Many studies measure only physical violence, a particularly problematic approach when findings indicate that over time in long-term relationships physical (including sexual) abuse decreases and psychological abuse remains (Fisher & Regan 2006; Harris 1996).

Unpicking “older”

Some new prevalence research offers insights on the experiences of older women of different ages. An interesting study by Mouton *et al* (2004) focused on “independent, cognitively intact” older women: “[Our] findings suggest that even for nondependent older women, physical and verbal abuse is occurring at rates similar to, or higher than, those for younger women” (609). Based on a cohort of 91,749 women from the Women’s Health Initiative in Texas, the study concluded that this abuse “poses a serious threat to their health” (605). In another study from the Women’s Health Initiative, Mouton (2003) reported that of the 1,245 women between 50 and 79 years old taking part in interviews, 58.5% “reported exposure to some type of abuse in their adult lifetime”; 22.8% reported some type of abuse in the previous year (1471). Interestingly, women exposed in the previous year “were more likely to be married. No other sociodemographic variable was significantly related to physical or verbal abuse 12 months prior to the baseline interview” (1471).

Wilke and Vinton (2005), in a secondary analysis of the National Violence Against Women Survey (United States, 1996-1996), looked at domestic violence across a number of age cohorts in a nationally representative sample of 8000 women and 8000 men. (The cohorts of women used were 18 to 29 year olds, 30 to 44 year olds, and 45+ year olds.) Although the study focused exclusively on physical violence, nevertheless the findings confirm that younger and older women’s experiences are more similar than different:

> *In terms of the extent and nature of domestic violence among the cohorts of women, there were far more similarities than differences. Although the incidence of child abuse in this population was high (64%), there were no statistical differences among the cohorts... . No differences among the cohorts were found in the type of perpetrator who committed the violence. About 94% of the respondents indicated that an intimate partner (a spouse or partner), rather than another family member... was the perpetrator (322).*

The following findings were particularly interesting:

- The 45+ cohort were more likely to be currently in a violent relationship than the younger cohorts (41% versus 36% for 30 to 44 year olds and 26% for 18 to 29 year olds).
- Duration of abuse was much longer for the oldest cohort (an average of 14.5 years versus 5.5 and 2.6 years, respectively).
- Overall, when asked about the most recent episode of violence, 72% of all respondents, had not reported the violence to the police.
- The 45+ women were more likely to report having a chronic disease or health condition, having a chronic mental health condition, and having used tranquilizers or sedatives and antidepressants in the last month (322-323).

Cohort, period and aging effects

Cohort, period and aging effects are described by Zink et al (2003), who comment that older women’s reasons for staying with abusers are the essentially same as younger women’s but reflect “meaningful difference in terms of intensity or degree.”

Cohort effects included lack of employability skills, lack of money, lack of education, needs of children, emotional attachments and shame (1422). More years invested in families and communities mean more to lose, and less education and fewer job skills mean fewer supports (higher barriers). And, as with our findings, “years of criticism and hostility seemed to intensify the shame and embarrassment”(1434).

Period effects were the historical context of older women’s lives, with childhoods spent in worlds untouched by feminist activism and decades spent living with unidentified abuse. For those women who had identified their abuse, help seeking was frustrated by “courts, police, doctors, and family... [that] upheld the sanctity and privacy of the domestic sphere” (1436).

Aging effects included "loneliness and the fear of loneliness," and "[h]ealth challenges for both victims and abusers were reasons to continue abusive relationships" (1437).

Zink *et al* (2006) comment that older women stay in or return to abusive relationships for the same reasons that younger women do, "however, many of these reasons are magnified in older women as a result of aging, cohort, and historical effects" (p 1412).

As Grossman and Lundy (2003) point out, racial and ethnic minority women are often missing in any significant number from studies. What data do exist come from the United States and may be problematic for transfer to UK women's experiences.

II What older women say about abuse and leaving

A number of studies offered insights about older women's interpretations of abuse and their attitudes about leaving partners. Some older women may be less able or less willing to identify their partners' or ex-partners' behaviour as abuse or violence. Fisher and Regan (2006) cite findings from a qualitative study by Zink, Regan, Jacobson, and Pabst (2003) that report that women indicated that "things in their marriage were okay now that it was only psychological/emotional abuse and that the physical and sexual abuse had decreased or stopped." Fisher and Regan comment that, because some older women distinguish between physical and non-physical violence in naming abuse, and because, in their findings, women experiencing abuse were likely to experience different kinds of abuse, "if an older woman does admit to one type of abuse, it is likely that she is experiencing or has experienced other types of abuse as well, and that she experiences abuse more than once and possibly often" (208).

Mears (2003), citing data collected in interviews with over 250 women in Australia, comments "... the stories also illustrated the unique difficulties faced by older women leaving a violent relationship. Foremost among their concerns was being unable to survive financially and being plunged into poverty or being inappropriately placed in residential care and losing their homes, families, and social networks" (1486).

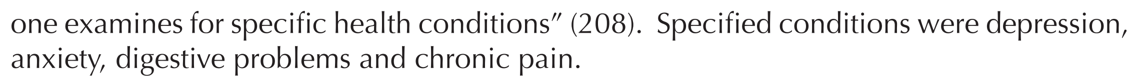
III Health outcomes

A number of reports focused on health outcomes related to older women's experiences of domestic violence. Fisher and Regan (2006) make the following comment:

> *It should not be too surprising that, given the paucity of older women abuse studies, our understanding of the health consequences for abused older women is woefully limited. The issues of abuse and its health consequences will not retreat anytime soon. Older women are a fast-growing population as the baby boomers enter into old age and their life expectancy continues to lengthen (200).*

In the same study, older women experiencing domestic violence were "significantly more likely to report more health conditions than those who were not abused." Older women reporting psychological/emotional abuse—"alone, repeatedly, or 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"(200).

The authors point out that practitioners should understand that "... women who are experiencing abuse may not report lower general health compared with women who are not being abused, yet are more likely to experience detrimental effects to their health if



one examines for specific health conditions" (208). Specified conditions were depression, anxiety, digestive problems and chronic pain.

Zink et al. (2005), reported on a U.S. prevalence study of 3,636 women over 55 years old in a primary care practice:

> *...our data confirm other studies that report depression and chronic pain as common among IPV victims. Although digestive problems only approached significance in our sample, it is a common condition in younger IPV victims. Thinking of these as "red flag" diagnoses, conditions frequently associated with IPV, should trigger health care providers to inquire about IPV when an older patient with 1 of these conditions is seen (887).*

The authors also commented that "[p]hysicians' rates for asking about IPV are less than 10%" (888).

Screening by health professionals

Mouton (2003) reported on a study of violence and health status among older women; while acknowledging the challenges to effectiveness of screening, he commented,

> *These findings suggest it is important for health practitioners to screen their older women patients for exposure to IPV.*
>
> *Useful screening strategies for health practitioners include routine screening at the initial visit, routine follow-up screening at 1- or 2-year intervals, and screening when new risk factors are identified.*

A similar recommendation emerged from the larger 2004 study from the Women's Health Initiative:

> *Although a recent article by Ramsay et al. challenges the effectiveness of screening for domestic violence... [o]ur results suggest that additional investigations regarding the impact of abuse in this population and the impact of screening for abuse in postmenopausal women should be encouraged (Mouton et al 2004, 611).*

Zink et al. (2003) concluded from a qualitative study with women over 55 years old that "Older women victims have difficulty initiating discussions about IPV with their providers. Providers are encouraged to identify signals of potential abuse and to create privacy with all patients to discuss difficult issues ... and to be knowledgeable about appropriate referrals" (908). Older women interviewed cited similar reasons for nondisclosure to those of younger women, but these reasons were "compounded by the generational mores of privacy about domestic affairs and society's lack of understanding and resource for IPV" (898). Not surprisingly, some women who had disclosed reported feeling "discounted and unsupported," and others reported receiving a supportive response, including "respect for their decisions to continue their abusive relationships" (898).

An interesting quantitative study from Australia of 45- to 50-year-old women examined relationships between domestic violence and use of health services (Loxton *et al*. 2004). The study authors reported that "Physical and psychological status accounted for the associations between domestic violence and higher health service us, with the exception of GP consultations, which remained associated with domestic violence (emphasis added)" (383). Because above-average use of services was only partially explained by health complaints, "it seems likely that women who have experienced domestic violence may be seeking consultations from GPs for reasons additional to health status" (383).

IV Service development

A number of new studies offer interesting ideas for service development and redesign to better meet the needs of older women. A key point is that older women are more likely to have been exposed to long-term trauma, are more likely to currently live with an abuser and are more likely to remain within the relationship. These circumstances argue for a new emphasis on services delivered to women who do not leave their abusers. "Because older women are more likely to remain in their abusive relationships, experts and researchers of IPV in older women have encouraged professionals to 'think outside the box' when crafting strategies to improve the safety of older abuse victims" (Zink et al. 2006, 852).

Zink *et al* (2006) carried out a series of qualitative interviews that focused on coping and experience of health care and offered four recommendations:

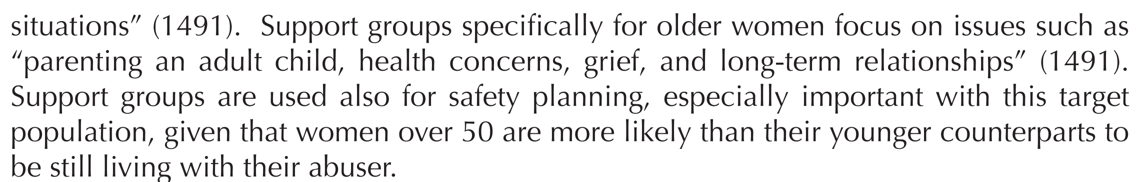
1. "[S]evere and life-threatening abuse is perpetrated by older, seemingly harmless, abusers... and providers should continue to assess clients for the presence of risks or lethality indicators" (861).
2. Because of the prevalence and escalation of emotional abuse of older women, providers need to identify risk and protective factors for ameliorating impact on health and well-being of older women. Important supports include "social support and spiritual or religious beliefs... helping women identify sources of support and linking them with services or resources" to reduce isolation. Providers may need to work with aged services to provide transportation (for survivor or abuser) to senior day activities or day care, to offer peer support groups for survivors in those settings, and to look at how home visits might be supportive.
3. It is important to identify and treat mental health problems undiagnosed in survivor and abuser. "When leaving may not be an option, appropriate management of diagnoses such as depression, anxiety, or oppositional behaviors may improve safety and quality of life."
4. Ongoing public education efforts are needed to communicate messages about abuse in venues that reach older survivors.

> Despite facing a Bermuda triangle of bad choices—staying, leaving, fighting back—many older women make major change when respectful support is available. (Brandl *et al*. 2003, 1495)

Support groups

Brandl *et al*. (2003) reported on provision of support groups for older women. Group work is seen as an effective mechanism for addressing isolation, providing safe opportunities for disclosure, offering information about dynamics of abuse, and "furnishing a forum to problem solve with others in similar

> Guiding principles for working with older abused women (excerpts from Brandl *et al*. 2003, 1501-1502
>
> - Believe the victim. Even if the victim says other things that seem unlikely, begin by assuming the older woman has been harmed or has experienced trauma at some point. If you have concerns about dementia, depression or delirium, contact a health care provider.
> - Do not assume that stress, poor family communication, or poor caregiving techniques are causing the problem. Assume it is power and control unless and until proven otherwise. Focus on victim safety and avoid colluding with the abuser.
> - Identify the victim's strengths and skills and build upon them.
> - Offer hope. Focus on offering strategies that promote victim safety and break isolation, support the victim's decisions, and provide additional information....
> - Support any decision the victim makes: staying, leaving, or leaving and returning to an abusive relationship....


situations" (1491). Support groups specifically for older women focus on issues such as "parenting an adult child, health concerns, grief, and long-term relationships" (1491). Support groups are used also for safety planning, especially important with this target population, given that women over 50 are more likely than their younger counterparts to be still living with their abuser.

Possible innovative approaches that consider older women's particular circumstances include: "... a home health agency could care for shelter clients, assisted living facilities could provide emergency shelter, and domestic violence advocates could provide services at senior centers" (1440).

Conclusions: Thinking about what older women really need

Perhaps the most compelling finding from this review is the need to adjust for bias to survivors who have left their abusers, given the evidence that older women often remain but still need and have a right to services.

> Violence against older women can no longer be left in the too hard basket. (Mears 2003: 1488).

In addition, the higher rates of psychological/emotional abuse experienced by older women argue for increased attention on appropriate interventions to address the impact of non-physical violence.

As mentioned above, we need to think "outside the box" for improving safety for older women. Collaborative efforts between domestic violence and elder abuse agencies are one practical strategy. Vinton (2003) reports on a project, part of the Elder Ready Communities initiative in Florida, designed in response to the recommendations of the Elder Domestic Violence Work Group. The work group consisted of older women survivors (service users), staff from elder affairs and from the domestic violence policy-level agencies, and representatives from domestic violence and social work agencies working at the coal face. Implementation included a public education campaign with the slogan "Domestic Violence: A Crime at Any Age" (1509), cross-training in social work, domestic violence and elder services agencies, renovating a refuge to be "elder-ready", collaborative service agreements such that community-based assisted living facilities provided space for older women experiencing domestic violence, and retrofitting of space in a senior centre to provide "respite and safety for elder victims awaiting case management" (1508).

Replicating the project design involved implementing a number of recommendations. For example, "executive directors of Area Agencies on Aging, community-based aging services agencies, and domestic violence centers should meet to discuss ways to collaborate on elder domestic violence issues; ... persons representing community-based facilities—notably, assisted living facilities—should be recruited" to serve on boards of local aging and domestic violence agencies, and professionals providing temporary and emergency housing and home-based care should consider how services can be provided to offer older women appropriate service choices (1511). In the year following the campaign, "the number of older women sheltered by the same number of domestic violence centers in Florida increased from 70 to 123," a 57% increase.

Older women taking the chance to tell their stories were reflected in numerous research articles (Mears 2003, Zink *et al*. 2003, 2006). Mears underlines the importance of women's stories: "Speaking out was an affirming and empowering experience for the women, no matter what their situation. They spoke of living with the pain of past violence and the liberating experience of discovering they weren't alone in living with this pain.... As younger women, there was no one to tell, nowhere to go..." (1486-1487).

Listening to older women's stories, involving older women in service design and re-design and including older women in policy and decision making are all tools for developing and delivering better policy and appropriate services.

References

Brandl, B., Hebert, M., Rozwadowski, J., & Spangler, D. (2003). Feeling safe, feeling strong: support groups for older abused women. Violence Against Women 9, 1490-1503.

Fisher, B, & Regan, S. (2006). The extent and frequency of abuse in the lives of older women and their relationship with health outcomes. The Gerontologist, 46(2), 200-209.

Fisher, B., Zink, T., Rinto, B., Regan, S., Pabst, S., & Gothelf, E. (2003). Overlooked issues during the golden years: Domestic violence and intimate partner violence against older women. Violence Against Women, 9, 1409-1416.

Grossman, S., & Lundy, M. (2003). Use of domestic violence services across race and ethnicity by women aged 55 and older: the Illinois experience. Violence Against Women 9, 1442-1452.

Harris, G. (2006). Domestic violence and abuse: elder abuse. Practice Nurse 31(8), 59-63.

Harris, S. (1996). For better or for worse: Spouse abuse grown old. Journal of Elder Abuse & Neglect, 8(1), 1-33.

Loxton, D., Schofield, M., & Hussain, R. (2004). History of domestic violence and health service use among mid-aged Australian women. Australian and New Zealand Journal of Public Health 28(4), 383-388.

Mears, J. (2003). Survival is not enough: Violence against older women in Australia. Violence Against Women 9, 1478-1489.

Mouton, C. (2003). Intimate partner violence and health status among older women. Violence Against Women 9, 1465-1477.

Mouton, C., Rodabough, R., Rovi, S., Hunt, J., Talamantes, M., Brzyski, R., & Burge, S. (2004). Prevalence and 3-year incidence of abuse among postmenopausal women. American Journal of Public Health 94(4), 605-612.

Rennison, C., & Rand, M. (2003). Nonlethal intimate partner violence against women: A comparison of three age cohorts. Violence Against Women, 9, 1417-1428.

Schei, B., Guthrie, J., Dennerstein, L., & Alford, S. (2006). Intimate partner violence and health outcomes in mid-life women: a population-based cohort study. Archive of Women's Mental Health 9, 317-324.

Straka, S., & Montminy, L. (2006). Responding to the needs of older women experiencing domestic violence. Violence against Women 12, 251-267.

Vinton, L. (2003). A model collaborative project toward making domestic violence centers elder ready. Violence Against Women 9, 1504-1513.

Wilke, D., & Vinton, L. (2005). The nature and impact of domestic violence across age cohorts. Affilia 20, 316-328.

Zink, T., Fisher, B., Regan, S. (2005). The prevalence and incidence of intimate partner violence in older women in primary care practices. Journal of General Internal Medicine 20, 884-888.

Zink, T., Jacobson, C., Regan, S., Fisher, B., & Pabst, S. (2006). Older women's descriptions and understandings of their abusers. Violence Against Women, 12, 851-865.

Zink, T., Jacobson, C., Regan, S., & Pabst, S. (2004). Hidden victims: the healthcare needs and experiences of older women in abusive relationships. Journal of Women's Health 13(8), 898-908.

Zink, T., Regan, S., Jacobson, C., & Pabst, S. (2003). Cohort, period and aging effects: A qualitative study of older women's reasons for remaining in abusive relationships. Violence Against Women, 9, 1429-1441.

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