Older Women's Descriptions and Understandings of Their Abusers

Therese Zink, C. Jeffrey Jacobson, Saundra Regan, Bonnie Fisher and Stephanie Pabst

Violence Against Women 2006 12: 851
DOI: 10.1177/1077801206292680

Violence Against Women
Volume 12 Number 9
September 2006 851-865

10.1177/1077801206292680
http://vaw.sagepub.com
hosted at
http://online.sagepub.com

Older Women's Descriptions and Understandings of Their Abusers

Therese Zink
University of Minnesota, Minneapolis
C. Jeffrey Jacobson
Saundra Regan
Bonnie Fisher
Stephanie Pabst
University of Cincinnati, OH

Thirty-eight women who were in abusive relationships since age 55 years were interviewed to understand their abuse stories, ways of coping, and health care experiences. In responding to these questions, women described the nature of the abuse perpetrated by their elderly partners and tried to "make sense" of what they had experienced and to define "who" these men were. This took various forms, from personal theories about aging, to labels (ethnic stereotyping, demonizing, pathologizing) to characterizations of the abuser's private versus public behaviors. The authors explore the implications these findings have for assisting the elderly victim and perpetrator.

Keywords: *abuse perpetrators; elderly victims; older women*

Intimate partner violence (IPV) is a problem in older couples (Rennison & Rand, 2003; Zink, Fisher, Pabst, & Regan, 2005). Annually more than 13,000 U.S. women age 55 years and older report nonlethal victimizations by an intimate partner (Rennison & Rand, 2003). In a phone survey of women older than age 55 receiving health care through a health care system in southwestern Ohio (N = 995), 3.1% reported experiencing IPV (physical, sexual, controlling behaviors, and threats of harm) in the past year and 5.4% since age 55 (Zink et al., 2005).

IPV in older relationships can be steady through the years, start later in the relationship when there is some transition or change, or begin with a second marriage or new relationship (Brandl & Meuer, 2000; Brandl & Raymond, 1997). Many older women remained in abusive relationships because they were unable to leave

Authors' Note: Supported under Award R605H23525 from the Attorney General of Ohio, Betty Montgomery. The points of view in this article are those of the authors and do not necessarily represent the official position of the office of Ohio Attorney General. Thanks to Barbara Rinto and Elizabeth Gothelf for their enthusiasm and thoughtfulness as members of the research team.

when they were younger. With aging and waning capacities, the couple becomes physically and financially dependent on each other or the day-to-day routine of the relationship (Zink, Jacobson, Regan, & Pabst, 2004; Zink, Regan, Jacobson, & Pabst, 2003).

Most of the research on abusers focuses on younger men (Fitch & Papantonio, 1983; Holtzworth-Monroe, Meehan, Herron, & Rehman, 2000; Holtzworth-Munroe & Meehan, 2004; Romans, Poore, & Martin, 2000; Rosen, Parmley, Knudon, & Fancher, 2002; Rosenbaum & Leisring, 2003; Widiger & Mullins-Sweatt, 2004). These studies describe the mental health diagnoses, including substance abuse, exposure to abuse during childhood, and the various batterer typologies. A recent discussion of the utility of male domestic violence offender typologies concludes that differentiating typologies is important for designing batterer interventions (Cavanaugh & Gelles, 2005).

To our knowledge, no study has examined profiles of the older abuser. Although this effort is limited to the *abuser* as defined through the self-report of the older victim, it is an attempt to begin to understand (a) the types of abuse perpetrated by older men against their spouses or dating partners and (b) the victim's interpretation of these experiences and behaviors. Understanding how older women make sense of their abusers may be helpful as we consider how to assist victims and perpetrators. Because older women are more likely to remain in their abusive relationships (Zink et al., 2003; Zink et al., 2004), 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 (Fisher et al., 2004; Vinton, 2000, 2003).

Method

Women who were currently or had been in an abusive relationship since age 55 years were recruited with flyers and by word of mouth at the local domestic violence and aging service agencies. Age 55 years was chosen as a cutoff because this group of women had been largely neglected in the IPV literature (Fisher et al., 2003). Because of a poor response in these venues, we placed ads in neighborhood newspapers. Ads read

> Are you a woman age 55 or older? Are you now or have you ever been involved in a relationship since age 55 where you were a victim of physical, emotional, or verbal abuse by your husband, boyfriend, or steady partner? The University of Cincinnati is looking for women 55 and older to participate in a research study about Intimate Partner Violence. If you are willing to tell us about your experience contact . . .

Neighborhoods were chosen to ensure ethnic and income diversity. As interviews were completed, transcripts were transcribed and reviewed continuously to assess for saturation on the topic of coping, and experiences in health care (Denzin & Lincoln, 1998). When we found no new responses to our coping questions and had a range of ages

and ethnicities (White and African American), we stopped running the ads. A total of 46 women were recruited between February and June 2003; 38 met study criteria (female, English speaking, experienced IPV since age 55 years) and completed the interview. The University Institutional Review Board approved study protocols.

Interview Procedures

After obtaining consent, a semistructured interview guide was followed. The first five interviews were conducted in person at a time and location safe for the participant. The remaining interviews were conducted by telephone. After explaining the purpose of the study and reviewing study criteria, an interested participant affirmed whether or not it was a safe time and place to talk. If not, an appointment was scheduled for another time. The participant was asked to hang up if the safety of her situation changed, and the interviewer would contact her again at another time. Several interviews were interrupted because the abusive spouse came into the room; these were continued at a later, safer time. Interviews lasted approximately 45 minutes and were audiotaped. After obtaining demographic and health information, the participant was invited to talk about her relationship with the abuser including the nature and frequency of abuse, explanations for remaining in the relationship, and the pattern of abuse over time. Sources of support and experiences in seeking help (health, church, legal, social services, and family) were also explored. For the interview grid see the appendix.

Participants

Table 1 describes the demographics of our sample. The median age was 58 years (range 55 to 90). Eighty-two percent of the women were White, and almost half had household incomes greater than US$40,000. All had adult children, and less than one half reported having had a paid job outside the home at any time. Most described emotional and/or psychological abuse and controlling behaviors. Almost three fourths (27/38) described being physically abused at some time in the relationship, and more than one third (13/34) recounted sexual abuse. Four reported more than one abusive relationship. At the time of the interview, 39% (15/38) remained in their marriage or relationships. The median length of the abusive relationship was 24 years (range 2 to 67). For women who had left their abusive relationship, the median length was 22 years (range 2 to 43).

Analysis

During the earlier analysis of transcripts regarding health and coping of older female IPV victims, we realized that participants had a lot to say about "who" their abusers were and what drove their actions. Sections pertaining to the abusers were coded and examined separately by three qualitative researchers (physician, anthropologist, nutritionist) using thematic analysis techniques. In this technique, researchers independently

Table 1
Participant Demographics ($n = 38$) and What They Told Us About Their Abusive Spouses and/or Partners

Characteristics		
Age (years): Mean (*SD*)	60.21	7.27
Median (Range)	58.00	(54 to 90)
	n	%
Ethnicity		
White	31	82
African American	7	18
Income[a]		
< U.S. $20,000	6	16
$20,000 to 39,999	14	37
$40,000 to 59,999	11	29
> $60,000	7	18
Paid employment (full- or part-time) at some time during their lives	17	49
Type of abuse throughout the relationship		
Emotional/verbal	36	95
Physical	27	7
Social control and/or economic	26	68
Sexual	13	34
Abusive relationship status		
Ongoing	15	40
Length of ongoing relationship in years		
Median (Range)	24.00 years	(2 to 67)
Mean (*SD*)	24.74	15.43
	n	%
Discontinued	23	60
Length of discontinued relationship in years		
Median (Range)	22.00 years	(2 to 43)
Mean (*SD*)	20.17	12.36
	n	%
Long-term marriage	23	60
Second relationship	11	29
Repetitive abusive relationships	4	11
Abuser details as reported by victim		
Substance abuse problem[b]	17	39
Mental health diagnosis	9	24
Full-time care due to physical health issues	3	8

a. 15 women did not report household income. Household income for these women was estimated based on 2000 Census data.
b. For women with more than one abuser, she was counted if she reported that at least one of her partners had had a substance abuse problem.

read and reread the interviews to identify the variety of different issues or themes that occur. Researchers met to compare the issues that they identified and to group the themes into similar topics (Spradley, 1979). Rereading and recategorizing themes occurred until consensus about the categories was reached (Borkan, 1999; Denzin & Lincoln, 1998). The quotations that best expressed the different issues were selected.

Prior to the in-depth analysis of the abuser-coded segments, we wrote down our preconceptions independently, then discussed them as a group. These were drawn from clinical experience and previous analyses (Zink et al., 2005; Zink et al., 2003; Zink, Jacobson, Pabst, Regan, & Fisher, 2006). Preconceptions included the codependence of the older abusive couple, the victim's powerlessness in the face of the abuser's controlling behavior (i.e., victim unable to drive, abuser refuses to let adult protective services or public health nurse into the home), the victim's willingness to protect and make excuses for the "mean old man."

The interview questions were more broadly concerned with health and coping rather than on the abuser per se. The data were self-report; corroboration was not possible given funding and safety constraints. After preliminary reviews of the abuser-coded segments, we decided to define the following basic questions for this analysis: (a) What kind of abuse was perpetrated in old age? And (b) How did the victim characterize, perceive, and make sense of her abusive partner?

Results

First, we describe the abusive behaviors of the elderly perpetrators and then the victims' characterizations of their abusive partners. In the discussion, we explore the implications these findings have for assisting the elderly abusive couple.

Types of Abusive Behaviors by the Elderly Perpetrators

As described by Brandl and colleagues, we found that physical, emotional, sexual, and social and/or financial abuse were described during the course of the relationship, within second relationships, or connected with some kind of status change (Brandl & Meuer, 2000; Brandl & Raymond, 1997). For example, one woman depicted 69 years of abuse in her marriage. Another described abuse with a boyfriend of 2 years after she was divorced from a 20-year marriage, and another described how the abuse started 10 years into the relationship: "I think his life was changing through his job, more opportunities were opening. . . . He was doing some traveling, a little taste of the world and, um, I think he got the big head."

Although women talked about years of abusive treatment, here we focus on their descriptions of abuse, which occurred since turning age 55 years. Supportive of previous research, the physical abuse decreased with age in our sample (Harris, 1996; Rennison & Rand, 2003). However, the emotional abuse continued and sometimes

escalated. Women who left their abusive relationships did so when extreme threats or acts of violence occurred, for example, when "he locked me out of the house, tried to shoot me, or burned the house down." With age, the power balance changed in some relationships; however, the abuse continued. Several victims became caretakers of their elderly disabled abusers. One woman who provided full care to her aged spouse reported experiencing a barrage of insults and complaints if she arranged respite or a caretaker so she could go to lunch with a friend. Another said, "he took his degeneration out on me."

Examples of the abusers' more recent and current behaviors are presented here as (a) threats with weapons, (b) physical abuse, (c) sexual abuse, and (d) psychological abuse. These categories are consistent with the Centers for Disease Control and Prevention (CDC) definition of *intimate partner abuse* (Saltzman, Fanslow, McMahon, & Shelley, 1999). Many women reported more than one form of abuse.

Several women reported that their spouses threatened them with weapons. A 60-year-old woman who had one of the most dangerous-sounding spouses in our sample reported that the abuse started 25 years into her 35-year marriage. She left him seven times before leaving for good. In his retirement, her spouse worked as a security guard, and in the final 2 years before she left, he tried to smother her, on another occasion he attempted to slit her throat, and finally he burned down the family home. She noted with some irony that their mutual physician considered her spouse "a sick old man who had a heart condition." The internist had no clue that her "sick husband" was capable of this abuse, and he thought "I was leaving him because he was sick."

Another 60-year-old woman "whose mother-in-law warned [her] not to marry him because of his temper" reported that the abuse escalated and that, "he choked me a couple of times and put a knife up to . . . the bottom of my chin." The day he left, "because he wanted out . . . he pushed me up against the wall, one of his favorite things to do . . . and banged my head." A 56-year-old woman who dated a man for 2 years reported, "He showed a friend's husband [and me] the sights on his guns. [She was not previously aware that he owned guns.] And said that if anybody ever crossed him." She felt he had made a pointed comment to her. These examples underscore the importance of safety and lethality assessments for elderly victims.

A majority of the women reported that *physical abuse* was part of the relationship early on but that it had decreased with age. The exceptions to this included one woman who managed her spouse's physical threats by fighting back or threatening to call family members. These threats appeared to hold the physical abuse in check. A 56-year-old woman who cared for her ill husband full-time reported shoving him and, as a result, there were no other physical episodes.

Sexual abuse was prevalent throughout the years in the forms of manhandling and marital rape but for the most part waned with age and appeared to take on a more psychological character. A 57-year-old woman who had tolerated forced sex earlier in her marriage and now provided full-time care for her husband reported how the sexual abuse continued: "He has had a stroke. . . . He sits there and masturbates all the time.

He can't do anything [sexually or physically to me], but to me that [masturbating] is abusing me." A 90-year-old woman, married for 67 years, who had suffered years of her husband "being very cruel during intercourse" was relieved at his declining virility. "Now he can't bear to touch me. . . . One good thing, he became impotent." One exception was a 55-year-old woman, married for 35 years who felt that with the years

> He's more demanding or expecting me to be sexually active with him at times that I think are inappropriate. Such as [when] I'm really sick with the flu. [When I was young] I think I pretty much went along with it, but . . . as the years have gone by, I've just kind of become more distant and . . . have become completely turned off.

Other women mentioned pornography as a form of sexual and psychological abuse. A 56-year-old woman talked about her boyfriend of 2 years:

> He leaves porn photos on the dining room table in envelopes. . . . I had some communication with him and that's what ended the relationship. I wasn't trying to tell him to give them up, I was only asking him to keep the information away from my grandchildren who were only 4 years old.

Another example was a woman whose husband was very secretive and threatening when confronted about the contents of his file cabinet, which turned out to be gay pornography.

Psychological abuse was extensive in the early years and continued into later years, to a much greater extent than physical and sexual abuse. For example, one woman told us: "I still can't put the garbage bag in right," "I still can't put toilet paper on the roll the right way." Some felt that the psychological abuse had "escalated over the years" to the point that "he destroys you; you are not even a person anymore." Other women suggested that the psychological abuse replaced the physical abuse that occurred earlier. A 55-year-old woman married for 22 years said, "He stopped the actual hitting, but he would throw things, destroy things. Always whoever he was angry at, he would take something that meant something to them and bust it." Another 55-year-old woman, married for 16 years, told us that, "he is wiser with age, but he uses his mouth." A 72-year-old woman, married for 53 years, told us, "He never hits me now, but threatens."

For many, the psychological abuse was cruel and menacing. For instance

> There was an incident toward the end where he couldn't find a kitchen knife . . . and he woke me up and said, "I'm not going to leave you alone until you tell me where the knife is." As it turned out, . . . after it was found, he remembered placing it on the windowsill. Just constant waking me up, you know, where is this, why didn't you do this? Every day. He worked a different shift, and every day it was constant, emotional abuse. We had birds, which was bad for my asthma. He dumped all the bird crap and feathers and all everywhere in the basement and in the den, and I had to get somebody to clean those up, I mean it has just been hell.

Controlling social activities and finances, a form of psychological abuse, was described as occurring throughout the relationships. In old age, a 67-year-old woman, married for 35 years, remarked, "He took out a restraining [order]—after I took him to court—that limited my contact with my friends at church." A 62-year-old, married for 38 years, said, "There are many a times where he's said . . . 'Well, I'm going to give you 15 minutes to go to the store, and 15 minutes back, and an hour to shop.'"

More than one fourth of the sample ($n = 10$) reported that the abusive spouse had extramarital affairs. Despite the risk of sexually transmitted infections, we categorized these behaviors as psychological abuse. Several women reported that even in old age "he is still having affairs," and that "he has a silver tongue . . . and can con any female from 2 to 90 years." One participant reported that her spouse had affairs with men and that she was afraid to tell anyone because she did not want to "out" him because he was a prominent professional in their small town.

The physical and sexual abuse declined somewhat; however, psychological abuse continued and even escalated, perhaps because of powerlessness and declining self-image of the men. Hence, later years may actually be a period of increased psychological vulnerability for elderly partnered women.

How the Victim Characterized and Made Sense of the Abuser's Behavior

We have already seen in comments such as "he took his degeneration out on me" that victims tried to make sense of their abusers' behaviors. In this example, the victim explains to the researcher, but also to herself, her understanding of the cause of her husband's behavior. This "making sense" of the abuser took various forms, from personal theories about aging and "degeneration" (seen here), to labels (ethnic stereotyping, demonizing, pathologizing), to characterizations of the private versus public nature of their behaviors. Although we did not specifically ask for these comments and understandings, they were commonly provided, and we hypothesize that these appraisals may play an important role in a victim's sense of control and her ability to cope with the stresses of IPV.

Various personality and mental health descriptors were used to characterize the abusers' behaviors, and in the process of naming or labeling, victims tried to explain and often excuse the abusers' conduct. Some women resorted to ethnic stereotypes and labels to describe their abuser's behavior: "He's a 'hot tempered Italian' or 'a hard headed or stubborn German.'" Some of these appeared to justify the abuser's behavior by suggesting that, for instance, because he's Italian, he has a temper.

Several women labeled their husbands "narcissistic," "very selfish," and "a kid who never grew up." One extreme example was a 73-year-old woman who, while walking alongside her husband through a parking lot, was forced to walk into a car. Her husband said, "You wouldn't touch me to move [me] would you?" The woman

told the interviewer: "People automatically move out of [one's] way without being told. . . . He does a lot of that. . . . My daughter said, 'He finds out what bothers you and then he agonizes you over it.'"

Some women focused on the abuser's anger explaining it as "he transferred his anger for his mother to me," or (as seen above) as result of his "degeneration." Like the participant who noted her abuser's "poor self-image," these women applied popular, psychodynamic explanations (including the myth that mothers cause mental illness in their sons) to make sense of the abuse.

Along these lines, several women were involved with partners whom they labeled as "women haters" or homosexual and/or bisexual. A 90-year-old woman found the term "misogynist" (hater of women) underlined in the dictionary. Finding this appeared to help her make sense of her husband's hatred of her:

> Through the years . . . I put 2 and 2 together and I thought, this is him. He hates women. Now he doesn't hate . . . he doesn't treat other women like me, but he doesn't think they can do anything, just men. . . . The word *homosexual* wasn't even used when I was young, and I don't know that he is . . . but you know in one of our arguments one time I said, "I think you're a homosexual," and he didn't say anything. . . . [laughing] He didn't argue with me, and I thought well maybe he is now.

A 60-year-old woman recently divorced from a 24-year second marriage said,

> I began to wonder, "what in the world was going on." He made quite a few trips to Washington, DC. [I thought] he had gotten involved in politics . . . but I come to find out later that he was actually . . . a member of this VCR club that was out of some gay bookstore in Washington. He was really into gay pornography.

For the women who characterized their partners as homosexuals, the abuse and the pain seemed to be related to their husbands' secrecy and that the women seemed to be targets of their spouses' frustration, anger, and possibly, shame. For example,

> We [the victim and the children] had to be really careful. He would get very angry over next to nothing. You know, always seemed very hostile and then every now and again, would just be pleasant. You were totally on guard all the time.

Several women tried to capture the public–private and the on-again, off-again dichotomy of their abusers' personalities. Drawing on popular religious and literary images, women commonly used expressions such as "he's an angel and a devil," or "he's like Jekyll and Hyde." One woman gave a graphic description of her husband who was a minister: "He would be this magnificent person on Sunday and then by Sunday afternoon all the blinds would close and . . . literally . . . and he'd darken everything and he wouldn't shave for the whole week."

In this case it appears that the abuser, while displaying some signs of depression, had not been seen or treated for mental health problems. It is not clear whether the victim saw these as signs of mental illness. However, many other women did recognize what they thought were signs of mental illness (including drug and alcohol problems), and several reported that their abusers had received treatment for psychiatric problems. Understanding women's conceptions of the distinction between normal and abnormal behavior may provide an important key to understanding their needs and decision-making processes as they age.

As seen above in some of the women's personality and psychodynamic attributions, victims needed a way to understand their abusers' behaviors, and in some cases, psychiatric labels were used. A 69-year-old woman remarked, "I was just thinking about the narcissism involved. I think it is a mental illness." Another woman thought it was better to pathologize than to demonize the abuser's behavior: "He had a sickness is how I looked at it. He wasn't a monster, but he definitely had a sickness."

A 62-year-old woman said,

> I've got a medical book here and I looked it up and I got the book and I put it in front of him and I said, "Look, this is what you are. You're either bipolar or you're in depression." I said, "You got all the symptoms, buddy." But . . . he is just so smart; he doesn't want to admit to it.

The use of these labels may help women understand their predicaments; however, it also points out the difficulties (i.e., the abusers' denial or nonrecognition) in getting the kind of psychiatric help needed.

Nearly one half of the women (n = 17) identified their abusers' alcohol or drug problems as exacerbating the abuse. Related to alcohol, women told us, "When he drank he was completely changed—abusive. I attributed [his] anger to the alcohol."

In contrast, another woman told us, "Alcohol seemed to quiet him. After alcohol treatment his [abusive] behavior was worse."

For those women whose abusers had been diagnosed and treated, women's understandings of their partners' mental health issues were shaped by the treatment and diagnoses the abusers received over time. Some women, committed to the relationship, worked with the mental illness. One woman, married for 25 years, noted, "His doctor put him on lithium and he was a little bit better on that than he had been." Another, married for 40 years, remarked, "[The doctor] put him on different medications and that would help for a while and then they would have to change them again. And right now . . . I don't even think he has half a brain [as a result of a stroke]." Sometimes seeking psychiatric treatment made the situation more tolerable; however, this was not always so. For another woman, psychiatric issues compelled her to remain in the abusive relationship: "Of course, at that time, he was going to a psychiatrist, and the psychiatrist was telling me no matter what he did to me, I should stay, you know, and that because he was sick, you know, and everything."

Discussion

In summary, the severity of physical and sexual abuse lessens with age; however, the potential for lethality is a concern no matter what the age or health of the perpetrator.

Psychological abuse takes a toll especially when cumulative over years. Women in long-term abusive relationships use labels, personality and mental health descriptors, to make sense of and sometimes justify the behaviors of their abusive spouses. How does this knowledge help us to assist older women in abusive relationships?

As discussed earlier, older women are often committed to continuing the abusive relationship because of generational mores and additional limitations associated with their largely domestic roles (Zink et al., 2003). As a result, we need to think about creative solutions for improving safety and quality of life for abusive couples. The women's descriptions and interpretations of their abusers raise the following considerations. First, severe and life-threatening abuse is perpetrated by older, seemingly harmless, abusers. These findings remind us that safety and lethality are still issues, and that providers should continue to assess clients for the presence of risks or lethality indicators (Campbell, 2004; Campbell et al., 2003).

Second, given the prevalence and potential escalation of emotional abuse in old age, it is important to explore the risk and protective factors for minimizing the impact on victims' health and well-being. Studies suggest that psychological abuse may result in poorer health (Coker, Smith, Bethea, King, & McKeown, 2000). Therefore, how do providers help to limit risk? The analysis of these interviews that examined how older women coped with years of abuse suggested that social support and spiritual or religious beliefs were important positive factors (Zink et al., 2006). Other studies with predominantly younger victims report the importance of social support as a buffer for mental health problems (Carlson, McNutt, Choi, & Rose, 2002; Coker et al., 2002). Therefore, helping women identify sources of support and linking them with services or resources to help them eliminate the isolation often associated with IPV may be helpful. For older women this may include working with aging agencies to provide transportation to senior day activities or senior centers, participation in IPV support groups, home visits or Meals on Wheels and encouraging participation in church activities if women have a religious affiliation. Of course, as described by the victim who sought respite services to give herself a break, the abuser may limit a victim's access to such opportunities.

Third, providers are encouraged to identify treatable mental health problems that are undiagnosed in the victim and the abuser. When leaving may not be an option, appropriate management of diagnoses such as depression, anxiety, or oppositional behaviors may improve the safety and quality of life for the couple.

Finally, ongoing public education efforts that talk about what is appropriate behavior in relationships and debunk the myths of the generational mores about tolerating abuse may help educate the public about what is acceptable and what is not.

It is important to communicate this message in venues that reach older victims, such as bingo halls, hair salons, and from the pulpit.

Several studies examine the typologies of batterers. Most of these have focused on younger men (Fitch & Papantonio, 1983; Holtzworth-Munroe & Meehan, 2004; Holtzworth-Monroe et al., 2000; Romans et al., 2000; Rosen et al., 2002; Rosenbaum & Leisring, 2003; Widiger & Mullins-Sweatt, 2004). Batterer subtypes are categorized across three dimensions: (a) severity and frequency, (b) generality (marital or extrafamilial), and (c) the perpetrator's psychopathology or personality disorder characteristics (Holtzworth-Monroe et al., 2000). Holtzworth-Munroe and Meehan (2004) identified four subtypes along these continua that have varied stability for 3-year's time. All subtypes can have a problem with alcohol. The mean age of Holtzworth-Munroe and Meehan's respondents was 35.6 years. The "family-only" subtype perpetrates low levels of marital violence and is the most stable. The "dysphoric or borderline" commits moderate-to-severe wife abuse, but not much outside the home. This type was the least stable over time. The "generally violent-antisocial" (GVA) perpetrator commits the most severe forms of marital and extrafamilial violence. For 3 years, a portion of this group moved to the final subtype, "low level antisocial." This group of perpetrators is in between the "family-only" and "generally violent-antisocial" groups. With time, the "low level antisocial" perpetrators who changed types moved into the "family-only" subtype.

Considering the personality and mental health descriptors expressed by the participants in the current study, all perpetrator subtypes were present with the exception of the GVA. Given the tendency of this type to migrate over time to less severe forms of abuse, this is not surprising in old age; GVA perpetrators are now subdued. Or the elderly GVA perpetrators may be in prison or, given the severity of the abuse, the victim may have left or be dead. Future perpetrator subtype research should be expanded to explore the typologies of older batterers so that interventions can be developed for the different subtypes.

One limitation of the current study is the self-reported and uncorroborated nature of the women's descriptions of their abusers. For this reason, we treated women's descriptions as not merely descriptive, but also interpretive, representing not facts about their abusers (e.g., psychiatric diagnoses) but expressions of how older IPV victims made sense of their abusers. Another limitation is the lack of saturation on abuser characteristics given that interviews and sampling procedures sought saturation on coping and health care-related issues. The current study was limited to women as victims because of the financial constraints of the grant. Despite these issues, the current study provides a window into a population rarely included in IPV research.

Continued effort is needed to educate the public about IPV among older couples and what is appropriate behavior in relationships. Professionals who work with elderly couples are encouraged to look for IPV and to work across disciplines to improve the safety and quality of life of elderly victims and perpetrators.

Appendix 1
Interview Questions

Demographics

Age
Race
Marital Status (Never married, married, divorced, widowed, separated, living together)
Children (sex, age, any live with you?)
Relationship status
Household income
Employed outside the home at some point (yes/no)

Medical History

Chronic conditions
- High blood pressure and/or low blood pressure
- Heart condition (coronary heart disease, angina, heart attack)
- Arthritis, rheumatism, other connective tissue disease
- Diabetes
- Asthma, bronchitis, emphysema, other lung disease
- Cancer
- Muscular or nerve disease (multiple sclerosis, muscular dystrophy, Lou Gehrig's)
- Stroke, brain hemorrhage, aneurysm
- Ulcers, vomiting, colitis
- Severe headaches, migraine
- Osteoporosis, brittle bones, other bone disease (joint replacement)
- Chronic pain, chronic fatigue
- Blindness, eye problems
- Depression
- Anxiety, panic disorder, other mental health disease
- Alcohol and/or drug problem

Questions About Relationship

1. Tell me about the relationship.
   Probes: Length and pattern of abuse, physical, emotional, sexual, social control
   Has the frequency of the abuse changed over time?
2. For those still with their partner:
   Probes: You've survived this for this *x* years, do you feel that you are now less at risk?
   Do you feel unsafe at times now?
   You hear about women getting killed by partners, have you been concerned in past?
   Are you ever concerned now?

Questions About Health Care

3. Have you ever sought help in a medical setting related to the abuse?
4. Have you ever told any of your doctors about the abuse?
   How often do you go to the doctor?
   What type of doctors do you see? (emergency room, primary care, specialist, psychiatry)
   Do you see the same doctor every time?
   Does your husband and/or partner see the same doctor?
   Probes: If so has that affected you sharing the domestic violence?
   If the patient says that she hasn't told anyone about the abuse—Ask have you told family, friends, etc.
   Why haven't you told anyone?
5. What has been helpful to you? What has not been helpful to you?
6. Do you want your regular doctor(s) to ask about abuse?
   Probes: Do you think doctors should know about domestic violence?
   Do you think your own doctor should ask you about the abuse and how things are going in your relationship?
7. Has domestic violence affected your health? (In what way?)
   Probe: How has it affected your health—the mechanism?
8. How did you make it through this?
   Probes: What is it about your personality or your sense of self that has helped you to cope with this?
   How do you keep going? Get up every morning?

References

Borkan, J. (1999). Immersion/crystallization. In B. Crabtree & W. Miller (Eds.), *Doing qualitative research* (pp. 179-194). Thousand Oaks, CA: Sage.

Brandl, B., & Meuer, T. (2000). Domestic abuse in later life. *Elder Law Journal*, *8*, 297-335.

Brandl, B., & Raymond, J. (1997). Unrecognized elder abuse victims. Older abused women. *Journal of Case Management*, *6*, 62-68.

Campbell, J. C. (2004). Helping women understand their risk in situations of intimate partner violence. *Journal of Interpersonal Violence*, *19*, 1464-1477.

Campbell, J. C., Webster, D., Koziol-McLain, J., Block, C., Campbell, D., Curry, M. A., et al. (2003). Risk factors for femicide in abusive relationships: Results from a multisite case control study. *American Journal of Public Health*, *93*, 1089-1096.

Carlson, B., McNutt, L., Choi, D., & Rose, I. (2002). Intimate partner abuse and mental health. *Violence Against Women*, *8*, 720-745.

Cavanaugh, M. M., & Gelles, R. J. (2005). The utility of male domestic violence offender typologies: New directions for research, policy and practice. *Journal of Interpersonal Violence*, *20*, 155-166.

Coker, A., Smith, P., Bethea, L., King, M., & McKeown, R. (2000). Physical health consequences of physical and psychological intimate partner violence. *Archives of Family Medicine*, *9*, 451-457.

Coker, A., Smith, P., Thompson, M., McKewon, R., Bethea, L., & Davis, K. (2002). Social support protects against the negative effects of partner violence on mental health. *Journal of Women's Health and Gender-Based Medicine*, *11*, 465-476.

Denzin, N., & Lincoln, Y. (1998). *Collecting and interpreting qualitative materials*. Thousand Oaks, CA: Sage.

Fisher, B., Zink, T., Pabst, S., Regan, S., Rinto, B., & Gothelf, E. (2004). Services and programming for older abused women: The Ohio experience. *Journal of Elder Abuse and Neglect*, *15*, 67-83.

Fisher, B., Zink, T., Rinto, B., Regan, S., Pabst, S., & Gothelf, E. (2003). Overlooked during the golden years: Violence against older women. *Violence Against Women*, *9*, 1409-1415.

Fitch, F., & Papantonio, A. (1983). Men who batter: Some pertinent characteristics. *Journal of Nervous and Mental Disease*, *171*(3), 190-192.

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

Holtzworth-Munroe, A., & Meehan, J. C. (2004). Typologies of men who are maritally violent: Scientific and clinical implications. *Journal of Interpersonal Violence*, *19*, 1369-1389.

Holtzworth-Monroe, A., Meehan, J., Herron, K., & Rehman, U. (2000). Testing the Holtzworth-Monroe and Stuart (1994) batterer typology. *Journal of Consulting and Clinical Psychology*, *68*, 1000-1019.

Rennison, C., & Rand, M. (2003). Non-lethal intimate partner violence: Women age 55 or older. *Violence Against Women*, *9*, 1417-1428.

Romans, S., Poore, M., & Martin, J. (2000). The perpetrators of domestic violence. *Medical Journal of Australia*, *173*, 484-488.

Rosen, L., Parmley, A., Knudon, K., & Fancher, P. (2002). Intimate partner violence among married male U.S. army soldiers: Ethnicity as a factor in self-reported perpetration and victimization. *Violence and Victims*, *17*, 607-622.

Rosenbaum, A., & Leisring, P. (2003). Beyond power and control: Towards an understanding of partner abusive men. *Journal of Comparative Family Studies*, *34*, 7-22.

Saltzman, L., Fanslow, J., McMahon, P., & Shelley, G. (1999). *Intimate partner violence surveillance uniform definitions and recommended data elements*. Atlanta, GA: Centers for Disease Control and Prevention.

Spradley, J. (1979). *The ethnographic interview*. Orlando, FL: Holt, Rinehart & Winston.

Vinton, L. (2000). *Final report on the "Response to Making Domestic Violence Services Elder Ready" project.* Tallahassee: Institute for Family Violence Studies, Florida State University.

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

Widiger, T. A., & Mullins-Sweatt, S. N. (2004). Typology of men who are maritally violent. A discussion of Holtzworth-Munroe and Meehan. *Journal of Interpersonal Violence*, *19*, 1396-1400.

Zink, T., Fisher, B., Pabst, S., & Regan, S. (2005). The prevalence and incidence of domestic violence in older women in primary care practices. *Journal of General Internal Medicine*, *20*, 884-8.

Zink, T., Jacobson, C. J., Pabst, S., Regan, S., & Fisher, B. (2006). A lifetime of intimate partner violence: Coping strategies of older women. *Journal of Interpersonal Violence*, *21*, 634-651.

Zink, T., Regan, S., Jacobson, J., & 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.

Zink, T. M., Jacobson, J. C. J., Regan, S., & Pabst, S. (2004). Hidden victims: The health care needs and experiences of older women in abusive relationships. *Journal of Women's Health*, *13*, 898-908.

Therese Zink is a family medicine physician and assistant professor at the University of Minnesota who sees patients, teaches medical students and residents, and does research in family violence.

C. Jeffrey Jacobson is a medical anthropologist and assistant professor at the University of Cincinnati who teaches and does research in health disparities.

Saundra Regan is a gerontologist at the University of Cincinnati who works in the Department of Research in the Department of Family.

Bonnie Fisher is a professor in the Division of Criminal Justice at the University of Cincinnati who teaches and does research in sexual assault.

Stephanie Pabst is a nutritionist who works in research at the University of Cincinnati.