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Stopping Older Person Gender-Based Violence in Women 55+ Through Promising Practices: A Scoping Review

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Abstract

Background: Intimate partner and family violence disproportionately affect women of all ages, but are often understudied in older populations. Older women also face numerous barriers to reporting these types of abuse. ***Purpose:*** This scoping review aimed to: (1) synthesize current knowledge about the utility and suitability of screening and intervention tools for older women (55+) experiencing intimate partner or family violence; and (2) identify and fill existing policy, practice, and research gaps with regard to current screening and intervention tools. ***Methods:*** A comprehensive search of the databases Medline, CINAHL, PsychINFO, AgeLine, Applied Social Science Index & Abstracts (ASSIA), and Sociological Abstracts was conducted. In addition, grey literature sources were searched using Google Scholar, ISI Social Sciences Citation Index, ISI Conference Proceedings Citation Index-Social Science & Humanities, Dissertations & Theses: Full Text, the Canadian Institute for Health Information (CIHI), and the National Institute of Health (NIH). After screening and selection, 42 documents were included for data extraction. ***Results*:** There were five major themes that emerged: (1) older women were not the specific targets of the studies/tools; (2) screening and intervention tools should address health outcomes; (3) tools identified were used or developed for some diverse populations; (4) two or more tools were used in combination; and (5) intervention tools should focus on social support and empowerment. ***Implications:*** Older women, especially those with intersectional identities, are rarely represented in studies of intimate partner and family violence, and are even less frequently the primary focus. Screening and intervention tools should address health outcomes, social support, and empowerment. Effective screening and intervention may stem from utilizing multiple tools in combination.

Key words: Intimate partner violence, domestic violence, older adults, women, screening, intervention

Key Messages

- Older women are rarely represented in studies of intimate partner and family violence, and are even less frequently the primary focus.
- Older women living with intersectional identities are further underrepresented in the research.
- Screening and intervention tools should address health outcomes, social support, empowerment; and multiple tools can be used effectively in combination.

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The World Health Organization (WHO, 2021) has recognized that "violence against women is a major human rights violation and a global public health problem" (p. VIII). Older women, however, have historically been left out of the majority of research and data pertaining to gender-based violence (GBV), as emphasis tends to be centred around women of reproductive age (Meyer et al., 2020). Although younger women are usually the ones who suffer the greatest share of GBV, older women may experience different forms of abuse than their younger counterparts, and are more likely to be the target of violence from various family members and/or carers (Meyer et al., 2020). For older women, perpetrators of abuse are often adult children as well as intimate partners, and can be multiple individuals, thus implicating different and complicated dynamics that inform reporting and response (Brijnath et al., 2021). There is a dearth of research that can inform service providers on identifying and addressing the barriers faced by older women in reporting and seeking help when they experience GBV (Beaulaurier et al., 2007; Meyer et al., 2020). As such, it is important to investigate the ways in which service providers can identify and respond to older women aged 55+ experiencing GBV, as well as the underlying issues that impact their capacity to do so.

What is Gender-Based Violence?

The United Nations (UN) asserts that GBV refers to:

> …harmful acts directed at an individual or a group of individuals based on their gender. It is rooted in gender inequality, the abuse of power and harmful norms. The term is primarily used to underscore the fact that structural, gender-based power differentials place women and girls at risk for multiple forms of violence (UN Women, n.d., para. 2).

GBV can also manifest in other ways, such as neglect, discrimination, or harassment (Government of Canada, 2022).

Intimate partner violence (IPV), defined as “any pattern of behavior that is used to gain or maintain power and control over an intimate partner” (UN Women, n.d., para 6), is a major subsection of GBV and is very commonly experienced by women around the world. IPV is not merely limited to physical violence as it can also include sexual, emotional, psychological, and economic violence. UN Women (n.d.) offers the following definitions for these five types of IPV. Physical violence occurs when an individual tries to harm or hurt another using physical force, and can also include property damage. Sexual violence involves a person forcing an intimate partner to engage in a sex act when the partner is not consenting. Emotional violence occurs when an individual undermines their partner’s self-worth, belittles their abilities, uses name-calling or verbal abuse, and damages their partner’s other relationships. Psychological violence happens when a person intimidates or threatens their partner, harms pets or destroys property, plays mind games, or isolates their partner from friends, family, school, and/or work. Finally, economic violence occurs when a person makes, or attempts to make, their partner financially dependent on them by controlling financial resources, withholding money (or access to money), and/or forbidding attendance at school or work.

Although men and boys also experience GBV, including IPV, this type of violence disproportionately affects women and girls on a global scale (Government of Canada, 2022; UN Women, n.d.). For example, in Canada, IPV rates in women are more than three and a half times higher than IPV rates among men in the most recent police reported data from 2019 that identified 79% of women aged 15 and over had experienced IPV (Government of Canada, 2022). In addition, women were significantly more likely to have experienced the severest forms of IPV, and of the people who had experienced IPV, women were four times more likely than

men to have been afraid of a partner at some point in their lives (Government of Canada, 2022). In the most extreme circumstances, GBV leads to femicide, which is the intentional murder of women and girls simply because of their gender identity (WHO, 2012).

The negative outcomes associated with GBV are extensive, and the impacts extend well beyond the individuals directly experiencing the abuse (Government of Canada, 2022). Oftentimes, experiences of IPV occur throughout the life-course with the effects spanning generations, leading to cycles of abuse within families and even communities (Government of Canada, 2022; Meyer et al., 2020).

Women, Gender, and Identity

Thus far in this paper, the term *women* has been used as an all-encompassing label to describe many different individuals. An individual's sex is determined by the different biological and physiological characteristics of being female or male, whereas gender refers to the socially constructed norms, behaviours, and roles that are generally associated with being a woman or man (WHO, n.d.). A person's gender identity "refers to a person's deeply felt, internal and individual experience of gender, which may or may not correspond to the person's physiology or designated sex at birth" (WHO, n.d., para. 3). It is the authors' intention to be as inclusive as possible in this review, including any persons that may identify as a woman, whenever the existing literature allows for such accommodations. The use of the terms *women* or *woman* will continue to be used broadly throughout this paper, and as such, are intended to be inclusive.

Due to intersectional identities that may impact their vulnerability to violence, some women are at an even greater risk of experiencing GBV in Canada (Government of Canada, 2022). These additional population groups are: Indigenous women and girls; Two Spirit, Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Intersex, and Asexual Plus (2SLGBTQQIA+) people; women living in Northern, rural, and remote communities; and women

living with disabilities. Further research has shown that Black women and immigrant women also experience high levels of GBV in Canada. According to the most recent data collected by the Government of Canada (2022), 61% of Indigenous women and 67% of 2SLGBTQQIA+ women had experienced IPV in their lifetime as compared to 44% of non-Indigenous or heterosexual women. Although only about 5% of Canadian women are Indigenous, 21% of all women killed by an intimate partner are Indigenous. Close to half of 2SLGBTQQIA+ individuals had been physically or sexually abused by an intimate partner in their lifetime, and 20% had experienced some form of IPV within the previous year, both of which were nearly double the rates indicated by heterosexual women. Furthermore, 55% of women with disabilities reported some form of IPV in their lifetime, and when examining 2SLGBTQQIA+ individuals with disabilities, this number skyrocketed to 71%. The rates of sexual assault perpetrated against women were over twice as high in Northern Canada than in Southern parts of the country, and rates of family violence against older adults were roughly 1.5 times higher in rural areas than in urban areas. Finally, 42% of Black women experienced IPV as compared to 20% of the overall visible minority population, and 26% of visible minority immigrant women in Canada had experienced IPV in their lifetime (Cotter, 2021).

Elder Abuse and Intimate Partner or Family Violence

Although there is no universally accepted definition for elder abuse, the WHO defines the abuse of older people (or elder abuse) 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. This type of violence constitutes a violation of human rights and includes physical, sexual, psychological and emotional abuse; financial and material abuse; abandonment; neglect; and serious loss of dignity and respect (WHO, 2022, para. 2).

As such, there are a number of parallels between elder abuse and IPV. Specifically, both are human rights violations caused by harmful acts which can occur in many different forms, such as physical, sexual, psychological, financial, and emotional modes of violence/abuse. This paper is situated at a crossroads of elder abuse and GBV, focusing on older women (aged 55 and over) who experience IPV and family violence. Thus, it is important to recognize the conceptual similarities, while also understanding the differences. For example, older women often face abuse/violence by various family members in addition to their intimate partners (Brijnath et al., 2021; Meyer et al., 2020), expanding the complexity of identifying and understanding GBV in this population. IPV is also described as a type of family violence (Government of Canada, 2022); hence this scoping review will explore both IPV and family violence under the broader umbrella of GBV. Data shows that 41% of older women have been victimized by family members in comparison to 25% of older men, and older women account for 62% of all senior victims of family-related homicide (Government of Canada, 2022).

Furthermore, the global prevalence rate of elder abuse has been rising, having increased substantially during the COVID-19 pandemic (WHO, 2022). A 2017 review by Yon and colleagues (2017), which examined 28 diverse nations, found that 15.7% of people aged 60 and older had been subjected to some type of abuse, which, when extrapolated to a global scale, indicated that one in six older adults (approximately 141 million people) were affected by elder abuse. Since the start of the pandemic in 2020, the number of older adults who experience elder abuse has continued to grow; this has been further compounded by the growing aging demographic (WHO, 2022). For this paper, older adults have been defined as those 55 and over to recognize that women and gender-diverse individuals in this age group have varied experiences and health outcomes that must be acknowledged.

There are also several barriers faced by older women in reporting IPV. Beaulaurier and colleagues (2007) found that the responses of family members, clergy members, the justice system, and community resources were major external barriers that contributed to the reluctance of older women reporting and seeking help when faced with IPV. Older women tend to exist within the margins when it comes to elder abuse and IPV, leaving them largely invisible to researchers in this area (Crockett et al., 2015). Evidence suggests that IPV persists across the lifespan and even carries increased health consequences for older women; however, the majority of research tends to focus on women of childbearing age (Crockett et al., 2015). In addition, research has found that a previous history of abuse (especially in childhood or middle age) is an important predictor of experiencing elder abuse (National Initiative for the Care of the Elderly [NICE], 2015). Therefore, it is vital to draw attention to the needs of older women facing violence from family members and/or intimate partners, and to ensure that older women can be identified by service providers who are able to effectively respond to their needs and provide assistance.

Objectives

The objectives of this scoping review are two-fold: (1) to synthesize current knowledge about the utility and suitability of screening and intervention tools for older women (aged 55 and older); and (2) to identify and fill existing research, practice, and policy gaps with regard to current screening and intervention tools. Given these goals, the following research questions were posed:

- What screening and intervention tools exist to help service providers identify and respond to intimate partner and family violence experienced by older women (55+)?
- What is the capacity of service providers to identify older women (55+) experiencing intimate partner and family violence using screening tools?

- What is the capacity of service providers to respond to intimate partner and family violence experienced by older women (55+) using intervention tools?

Methods

This scoping review has been structured around Arksey and O'Malley's (2005) five-stage framework: (1) development of a research question; (2) identification of relevant studies; (3) study selection; (4) charting the data; and (5) collecting, summarizing, and reporting the results. All five stages were supported by experts in the field of elder abuse and IPV, who provided invaluable feedback throughout the process, as well as in the consultation phase of Arksey and O'Malley's (2005) optional stage six.

Search Strategy

A Research Librarian assisted in the selection of appropriate search terms to ensure all relevant keywords were captured. The search terms were comprised of synonyms with appropriate use of truncation symbols for the following terms: older adults AND women AND (intimate partner violence OR family violence OR abuse) AND (screening OR intervention OR tool). Please refer to Appendix A for a full list of all search terms, including keywords and subject headings. Furthermore, results were filtered to only retrieve articles published after the year 2000, in order to limit the search to recent literature. Six academic databases were searched: Medline, CINAHL, PsychINFO, AgeLine, Applied Social Science Index and Abstracts (ASSIA), and Sociological Abstracts. In addition, grey literature documents were retrieved from six sources: ISI Social Sciences Citation Index, ISI Conference Proceedings Citation Index - Social Science & Humanities, Dissertations & Theses: Full Text, the Canadian Institute for Health Information (CIHI), the National Institute of Health (NIH), and Google Scholar. Full documentation of the grey literature search terms can also be found in Appendix A. The search process was carried out by the authors between August and September of 2022.

Screening Process

A total of 10,485 scholarly articles were obtained from the scholarly databases: 4,830 from Medline; 2,105 from CINAHL; 2,451 from PsychINFO; 44 from AgeLine; 604 from ASSIA; and 451 from Sociological Abstracts. The titles and abstracts were imported to the reference management software Covidence, wherein 2,537 duplicates were removed, resulting in 7,948 articles available to undergo title and abstract screening. At this stage, the inclusion criteria for articles were: available in English or French language; qualitative, quantitative, mixed methods, or theoretical commentary; mentioned women and/or older adults; the target populations experienced intimate partner or family violence or elder abuse; and mentioned screening or intervention methods. Articles were excluded if they were: written in a language other than English or French; not the correct methodology (i.e., other scoping or literature reviews or other forms of secondary data collection); target populations did not include older adults and/or women (i.e., specific to men/boys, children/adolescents, or young/reproductive aged women); target populations experienced abuse from individuals other than intimate partners or family members (e.g., strangers, friends, acquaintances, colleagues, etc.); and no mention of screening or intervention tools, or if the tools were geared towards other health or social issues. An independent researcher provided assistance in carrying out a French language search in which one article was found, but this article did not meet the inclusion criteria.

After searching the grey literature databases, an additional 75 documents were retrieved based on the same criteria for title and abstract screening. The first 100 documents from each grey literature source were searched, in accordance with Pham and colleagues' (2014) approach to conducting scoping reviews. As per Arksey and O'Malley (2005), if any article's relevance was unclear at the title and abstract screening, it was also included for full-text review. Following title and abstract screening, 426 articles retrieved from scholarly databases

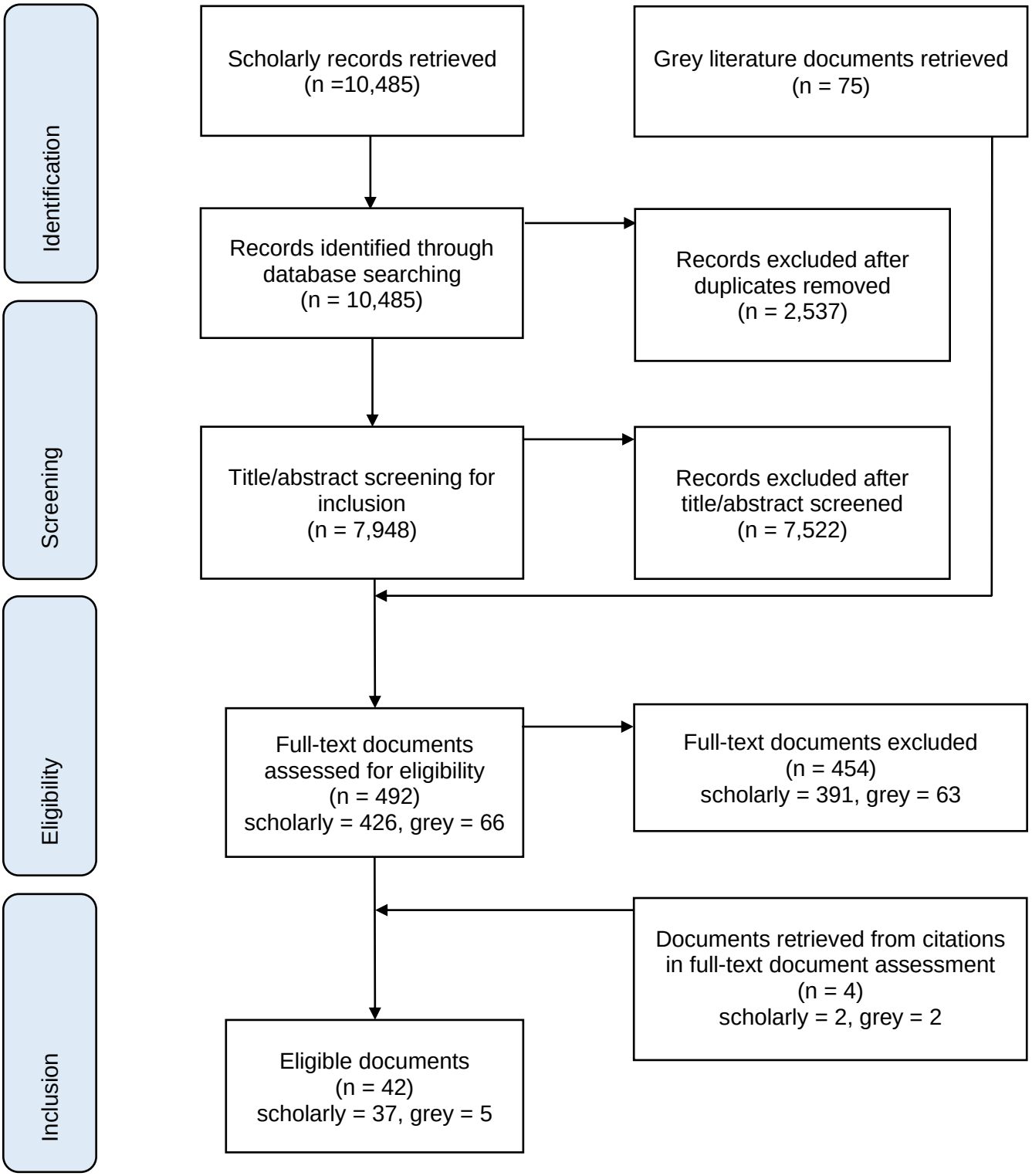
qualified for full-text screening. In addition, 66 documents retrieved from the grey literature sources were also assessed for eligibility.

Selection Process

Based on the research questions, further inclusion and exclusion criteria were developed for full-text screening and selection. Articles were included if the target population specifically included women aged 55 and older and they addressed the application of screening or intervention tools. Articles were excluded if the target populations did not include older women and if they did not examine the use of screening or intervention tools to identify or respond to IPV. Full-text versions of each document were assessed independently by two researchers (any conflicts were resolved by discussion or a third reviewer, if necessary), utilizing the inclusion and exclusion criteria. After full-text reviews, 391 articles were excluded. As a result, a total of 35 articles from scholarly databases and three (3) documents from grey literature databases were determined eligible for inclusion. Manual searches were conducted on the reference lists of the documents deemed eligible for inclusion after full-text review, and this process yielded an additional four (4) documents (two scholarly articles and two grey literature documents) for inclusion. Overall, a total of 42 documents were included in this scoping review. The full screening and selection process is illustrated via a PRISMA flow diagram (Moher et al., 2009) in Figure 1.

Figure 1

PRISMA Flow Diagram Demonstrating Search, Screening, and Selection Processes



Data Extraction and Analysis

Data were extracted from each of the 42 articles included in this review according to the following headings: Author(s) and Year of Publication, Country of Origin, Study Population, Study Design, Screening and/or Intervention Tools, Outcomes, and Important Findings. The complete data extraction table is referenced in Appendix B. Throughout the data extraction process, emerging themes were charted based on patterns observed by the research team. A full list of the major themes and corresponding articles can be found in Appendix C. After the data extraction was completed and a full list of screening and intervention tools was outlined, subject experts were once again consulted for their input. The experts were able to provide the names of additional tools that were not captured in the literature search, but were used by stakeholders to help identify and respond to IPV or family violence in older women. The results from this consultation exercise and the corresponding tools are reported separately from those found in the literature searches.

Results

Descriptive Overview

The majority of the studies included in this scoping review were conducted in the United States (U.S.) (67%), followed by Canada (12%), Australia (5%), Hong Kong (5%), and Brazil, Denmark, Iceland, India, Iran, the Netherlands, South Africa, South Korea, Turkey, and the United Kingdom (U.K.) (each 2%). Sample sizes ranged from 21 to 10,241 participants, and included, on average, 64.1% Caucasian, 27.8% Black, and 13.8% Indigenous women (see Figure 2); however, only 21 studies (50%) reported on Black populations, and nine (9) studies (21%) reported on Indigenous populations. Caucasian participants ranged from 29% up to 91%, Black participants from 2% to 100%, and Indigenous participants from 0.2% to 100%. The mean age of study participants was 42.5, with only five (5) studies (12%) specific to older adults aged

55 and over. Three (3) studies (7%) reported on rural populations, each respectively identifying 16%, 22.4%, and 100% of their populations to be living rurally. Only one study mentioned its participants were majority French speakers (90.6%), while two studies each examined Spanish, Korean, and Chinese speakers (see Figure 3). One study was specific to Icelandic speakers, one to Portuguese speakers in Brazil, and one was limited to women speaking Turkish. Finally, there were two studies (5%) that mentioned non-heterosexual women, of which one study was specific to the 2SLGBTQQIA+ community, and the other found merely 4% of its participants were non-heterosexual (see Figure 4).

Figure 2

Mean Racial Demographics (%)

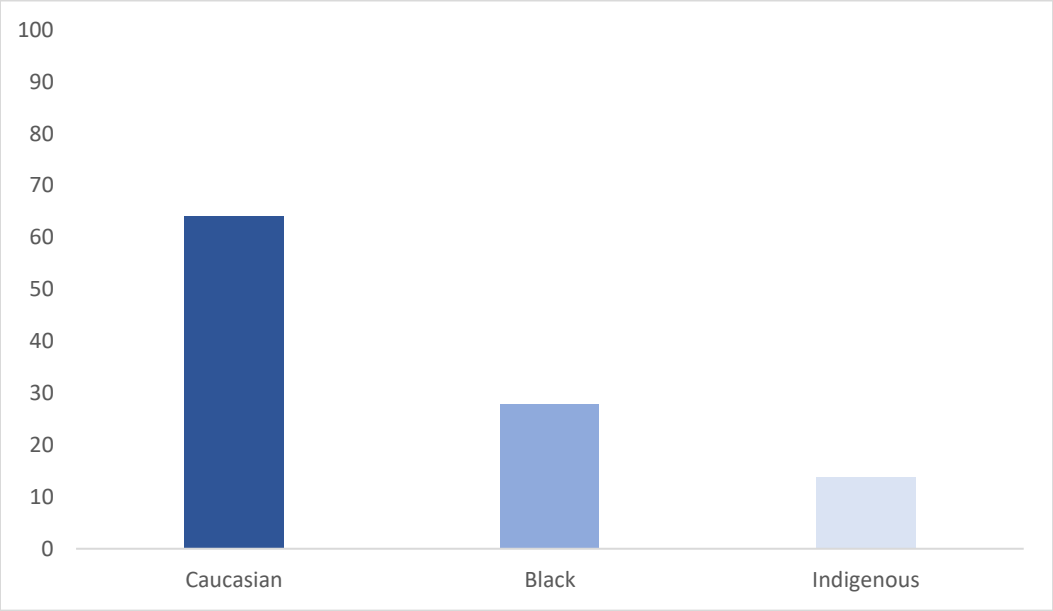


Figure 3

Language Representation (%)

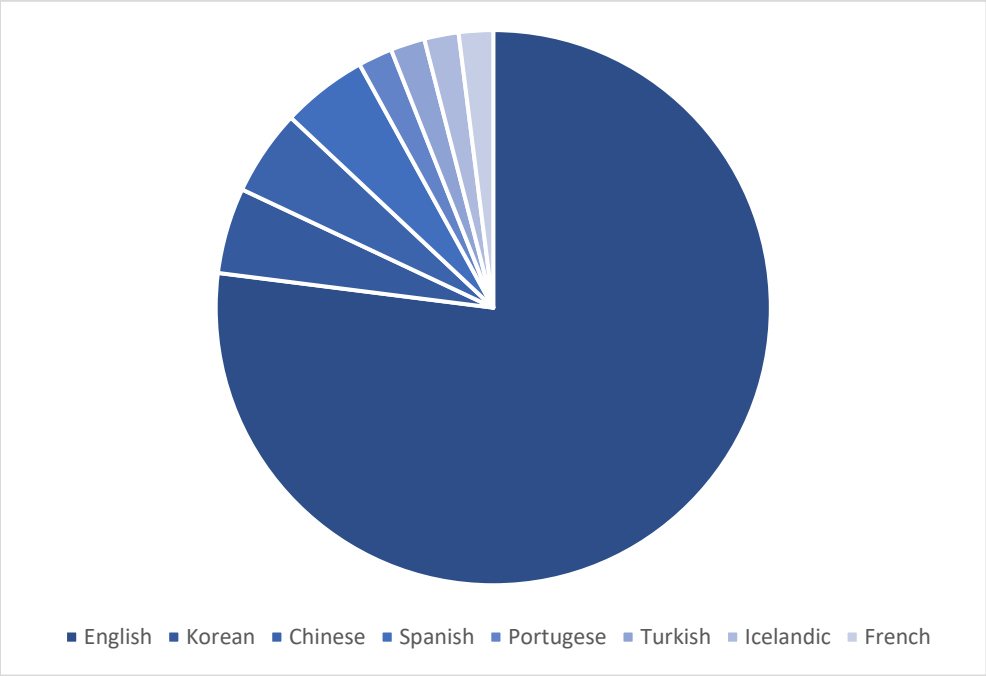
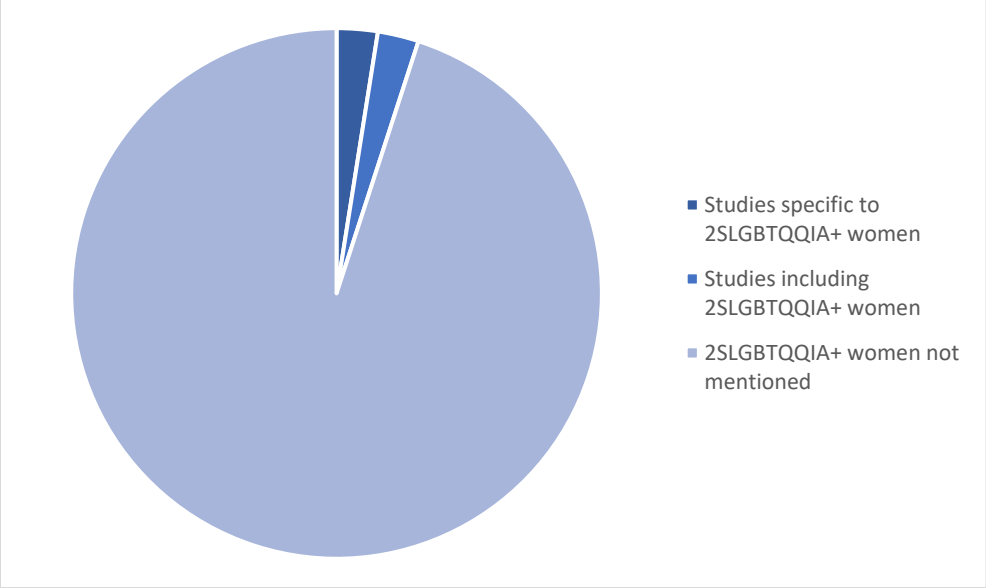


Figure 4

2SLGBTQQIA+ Representation (%)



A total of 33 screening and/or intervention tools were identified (as demonstrated in Table 1), with the most popular being the CTS2 (Revised Conflict Tactics Scale; 17%), the PVS (Partner Violence Screen; 12%), the WEB (Women's Experience with Battering; 12%), the AAS (Abuse Assessment Screen; 10%), and the BRFSS (Behavioral Risk Factor Surveillance System; 10%). Further, 7% of studies utilized the CAS (Composite Abuse Scale), HITS (Hurt, Insult, Threaten, and Scream), E-HITS (extended HITS), ISA (Index of Spousal Abuse), and WAST (Women Abuse Screening Tool), followed by 5% of studies that employed the HARK (Humiliation, Afraid, Rape, Kick), and VASS (Vulnerability to Abuse Screening Scale). Finally, 2% of studies identified the following tools: CRAT-V (Chinese Risk Assessment Tool for Victims), DA-5 (5-Item Danger Assessment), HELPP (Health, Education on Safety, and Legal Support and Resources in IPV Participant Preferred), HARASS Instrument, iHEAL (Intervention for Health Enhancement After Leaving), IA (Identity Abuse) Scale, IJS (Intimate Justice Scale), IMAGE (Intervention with Microfinance for AIDS and Gender Equity), KWAIS (Korean Women's Abuse Intolerance Scale), KWAST (Korean Women's Abuse Screening Tool), NET (Narrative Exposure Therapy), PCEP (Pleasure-Centered Education Program), PMWI (Psychological Maltreatment of Women Inventory), PRP (Personal and Relationship Profile), Revised SES (Sexual Experiences Survey), SAFE (Stress/Safety, Afraid/Abuse, Friends/Family, Emergency Plan), STaT (Slapped, Threatened, and Throw [things]), SVAWS (Severity of Violence Against Women Scale), TREM (Trauma Recovery and Empowerment Model), short-WAST (shortened version of WAST), and the Questionnaire from the WHO's Multi-Country Study on Women's Health and Domestic Violence Against Women. Six (6) of the tools (18%) identified through this scoping review can be described as interventions (TREM, HELPP, IMAGE, NET, PCEP, and iHEAL), while the remaining 82% are screening tools.

Table 1

Screening and Intervention Tools by Study

Tool	Number of Studies, N (%)	Studies by Author
CTS2	7 (17)	Chan (2012); Chan et al. (2010); DiVietro et al. (2018); Koziol-McLain et al. (2001); Liles et al. (2012); Moreau et al. (2015); Scheer et al. (2019)
PVS	5 (12)	Halpern et al. (2006); Halpern et al. (2009); Hewitt et al. (2011); Rhodes et al. (2006); Sprague et al. (2013)
WEB	5 (12)	Bonomi et al. (2006a); Bonomi et al. (2006b); Bonomi et al. (2007); Coker et al. (2007); Guruge et al. (2012)
AAS	4 (10)	Coker et al. (2007); Glass et al. (2001); Rhodes et al. (2006); Varcoe et al. (2017)
BRFSS	4 (10)	Bonomi et al. (2006a); Bonomi et al. (2006); Bonomi et al. (2007); Koziol-McLain et al. (2001)
CAS	3 (7)	Hegarty et al. (2005); Orang et al. (2018); Sohal et al. (2007)
HITS	3 (7)	Bonds et al. (2006); Lutgendorf et al. (2017); Miszkurka et al. (2016)
E-HITS	3 (7)	Chan et al. (2010); Dichter et al. (2017); DiVietro et al. (2018)
ISA	3 (7)	Cook et al. (2003); Guruge et al. (2012); Pranjape et al. (2006)
WAST	3 (7)	Fogarty & Brown (2002); Sprague et al. (2013); Svavarsdottir & Orlygsdottir (2009)
HARK	2 (5)	Clark et al. (2019); Sohal et al. (2007)
VASS	2 (5)	Dantas et al. (2017); Schofield & Mishra (2003)
CRAT-V	1 (2)	Chan (2012)
DA-5	1 (2)	Clark et al. (2019)
HELPP	1 (2)	Constantino et al. (2015)

Tool	Number of Studies, N (%)	Studies by Author
HARASS Instrument	1 (2)	Sharps et al. (2001)
iHEAL	1 (2)	Varcoe et al. (2017)
IA Scale	1 (2)	Scheer et al. (2019)
IJS	1 (2)	Jory (2004)
IMAGE	1 (2)	Knight et al. (2020)
KWAIS	1 (2)	Choi et al. (2008)
KWAST	1 (2)	Choi et al. (2008)
NET	1 (2)	Orang et al. (2018)
PCEP	1 (2)	Tambling et al. (2012)
PMWI	1 (2)	Scheer et al. (2019)
PRP	1 (2)	Chan (2012)
Revised SES	1 (2)	Moreau et al. (2015)
SAFE	1 (2)	Bonds et al. (2006)
STaT	1 (2)	Paranjape et al. (2006)
SVAWS	1 (2)	Gerber et al. (2005)
TREM	1 (2)	Bowland et al. (2012)
short-WAST	1 (2)	Halpern et al. (2006)
WHO Questionnaire	1 (2)	Santas et al. (2020)

Major Themes

There were five major themes that emerged from the data extraction: (1) older women were not the specific targets of the studies/tools; (2) screening and intervention tools should address health outcomes; (3) tools were used or developed for some diverse populations; (4) two or more tools were used in combination; and (5) intervention tools should focus on social support and empowerment. A table demonstrating which studies corresponded with each of the five themes can be found in Appendix C. After the themes were charted, it was found that 39 studies (93%) were aligned with theme one, 24 studies (57%) and 21 studies (50%) fell into themes two and three respectively, 15 studies (36%) belonged in theme four, and nine (9) studies (21%) applied to the fifth and final theme.

Theme One: Older Women Were Not the Specific Targets of the Studies/Tools

As the most frequently identified theme, this highlighted how few studies and/or tools were focused specifically on older women as the target population. Only three studies in this scoping review had sample populations solely made up of older women (Bonomi et al., 2007; Bowland et al., 2012; Schofield and Mishra, 2003). A further two studies were focused on older adults, but not specific to women, ranging from 52.8% (Miszkurka et al., 2016) to 76.2% (Dantas et al., 2017) female participants. In addition, there were three more articles that comprised men and women of varying ages in their studies (Clark et al., 2019; DiVietro et al., 2018; Scheer et al., 2019). Finally, a total of 28 articles included women into their mid-60s or did not elaborate on the top age groups of their sample populations' ages beyond participants in their 60s; however, there were nine (9) articles that did study the experiences of older women into their 70s, 80s, and 90s (Choi et al., 2008; Dichter et al., 2017; DiVietro et al., 2018; Knight et al.,

2020; Koziol-McLain et al., 2001; Liles et al., 2012; Moreau et al., 2015; Sharps et al., 2001, Sohal et al, 2007).

Theme Two: Screening and Intervention Tools Should Address Health Outcomes

Researchers found that women commonly sought out and utilized healthcare services, and a number of mental and physical health outcomes were associated with women experiencing IPV or family violence. There were 15 studies that found women with a history of intimate partner or family violence were presenting to the emergency department (ED), general practitioners' offices, or using other healthcare services as a result (Clark et al., 2019; Gerber et al., 2005; Glass et al., 2001; Guruge et al., 2012; Halpern et al., 2006; Halpern et al., 2009; Hewitt et al., 2011; Jory, 2004; Paranjape et al., 2006; Rhodes et al., 2006; Santas et al., 2020; Schofield and Mishra, 2003; Sharps et al., 2001; Sohal et al., 2007; Sprague et al., 2013). One of these studies specifically addressed the use of healthcare services prior to eventual femicide (Sharps et al., 2001). Additionally, nine studies (Bonomi et al., 2006a; Constantino et al., 2015; Glass et al., 2001; Guruge et al., 2012; Jory, 2004; Miszkurka et al., 2016; Orang et al., 2018; Schofield and Mishra, 2003; Varcoe et al., 2017) noted that women encountered several mental health issues, including depression, anxiety, stress or post-traumatic stress disorder (PTSD), and anger, as a result of their victimization. Furthermore, six articles identified injuries (particularly to the head, neck, and face), pain, and infections as reasons for women to seek medical attention after experiencing physical forms of abuse (Bonomi et al., 2006a; Glass et al., 2001; Halpern et al., 2006; Halpern et al., 2009; Sprague et al., 2013; Varcoe et al., 2017). Four studies found that negative behaviours related to smoking, drinking, or substance use were linked to experiences of IPV or family violence (Gerber et al., 2005; Hewitt et al., 2011; Miszkurka et al., 2016; Svavarsdottir and Orlygsdottir, 2009). Additionally, three studies discussed general physical health challenges that require attention (Bonomi et al., 2006a;

Bowland et al., 2012; Guruge et al., 2012), two studies identified sexual health issues that should be addressed (Knight et al., 2020; Tambling et al., 2012), another two examined chronic illness or active health conditions as tied to victimization (Svavarsdottir & Orlygsdottir, 2009; Varcoe et al., 2017), and one discussed falls or mobility issues as linked to experiences of abuse (Miszkurka et al., 2016).

Theme Three: Tools Were Used or Developed for Some Diverse Populations

Exactly half of the articles explored the use of screening and/or intervention tools amongst diverse groups. Most predominantly, majority Black populations were represented in five studies (Cook et al., 2003; Halpern et al., 2006; Paranjape et al., 2006; Rhodes et al., 2006; Tambling et al., 2012), ranging from 53.25% up to 100% of the study participants. Rural populations were discussed in three studies (Bonomi et al., 2007; Knight et al., 2020; Santas et al., 2020). Two studies were focused on individuals of Korean descent (Choi et al., 2008; Liles et al., 2017), another two were specific to Chinese individuals (Chan, 2012; Chan et al., 2010) and a further two articles mentioned Spanish speakers (Fogarty & Brown, 2002; Hewitt et al., 2011). Single studies examined Icelandic (Svavarsdottir & Orlygsdottir, 2009), Turkish (Santas et al., 2020), Iranian (Orang et al., 2018), Brazilian (Dantas et al., 2017), and French speaking (Moreau et al., 2015) individuals. Although a handful of articles mentioned only sparing percentages of Indigenous participants, one article was dedicated to Indigenous women in Canada (Varcoe et al., 2017). Varcoe and colleagues (2017) were able to tailor their study for Indigenous women by applying critical theoretical and decolonizing approaches to their process. This was achieved through guidance from Indigenous women with research expertise specific to IPV, the articulation of an Indigenous lens (including using Cree concepts to identify key aspects), and interviews with Indigenous Elders living in the study setting. There was also a single study that examined women living in a military setting, as either members themselves or

as partners of military personnel (Lutgendorf et al., 2017). Finally, Sheer and colleagues (2019) had the lone study that targeted entirely 2SLGBTQQIA+ individuals. This study examined identity abuse, a unique pattern of IPV specific to the 2SLGBTQQIA+ population, which "refers to the ways that abusers may use homophobic, biphobic, and transphobic societal and structural norms against their LGBTQ partner, discrediting, undermining, or devaluing their already stigmatized sexual or gender identity" (Sheer et al., 2019, p. 327).

Theme Four: Two or More Tools Were Used in Combination

A selection of studies employed multiple tools in various combinations. The tool most commonly used in tandem with others was the WEB (Bonomi et al., 2006a; Bonomi et al., 2006b; Bonomi et al., 2007; Coker et al., 2007; Guruge et al., 2012), followed closely by the BRFSS (Bonomi et al., 2006a; Bonomi et al., 2006b; Bonomi et al., 2007; Koziol-McLain et al., 2001) and the CTS2 (DiVietro et al., 2018; Koziol-McLain et al., 2001; Moreau et al., 2015; Scheer et al., 2019). Additionally, the AAS (Coker et al., 2007; Rhodes et al., 2006; Varcoe et al., 2017), PVS (Halpern et al., 2006; Rhodes et al., 2006; Sprague et al., 2013), and WAST (Halpern et al., 2006; Sprague et al., 2013) were each utilized in multiple studies with simultaneous screening and/or intervention tools. The WEB, BRFSS, CTS2, AAS, PVS, and WAST were also among the most commonly used tools included in this scoping review on the whole. Furthermore, CAS (Orang et al., 2018), DA-5 (Clark et al., 2019), E-HITS (DiVietro et al., 2018), HARK (Clark et al., 2019), IA Scale (Scheer et al., 2019), iHEAL (Varcoe et al., 2017), ISA (Guruge et al., 2012), NET (Orang et al., 2018), PMWI (Scheer et al., 2019), and Revised SES (Moreau et al., 2015) were each applied once in combination with another tool(s). In some cases, the researchers utilized multiple tools for tool development and validation purposes, or to examine the agreement between tools. In other studies, researchers were employing the use of multiple tools to capture different types of IPV (e.g., physical and psychological). Finally, there

were two studies (Orang et al., 2018; Varcoe et al., 2017) that examined the application of a screening tool followed by an intervention tool.

Theme Five: Intervention Tools Should Focus on Social Support and Empowerment

Researchers identified aspects of interpersonal relationships that were impacted by the tools, as well as the role played by intervention group dynamics. There were four studies (Constantino et al., 2015; Knight et al., 2020; Liles et al., 2012; Schofield & Mishra, 2003) that examined social capital or social support as targets of the tools. In a comparison of online and face-to-face educational interventions, it was found that both tools increased the personal and social support for women experiencing IPV, but more significant improvements were noted in the online group (Constantino et al., 2015). Knight and colleagues (2020) found that improving social capital alongside economic empowerment was a potential mechanism to augment IPV reduction.

In the study by Liles and colleagues (2012), it was found that women under 40 years of age had greater social support, as well as higher rates of IPV, than older women; however, having social support did not correlate with experiencing IPV in women aged 40 and older. Immigration stress (e.g., stress associated with language barriers, experiencing discrimination, not feeling at home, etc.) was a better predictor of abuse for the older women. It was also found that women who felt more socially dejected, vulnerable, and dependent upon others had fewer social supports (Schofield & Mishra, 2003). Additionally, perceptions of (dis)empowerment were mentioned in three studies (Bonomi et al., 2006b; Tambling et al., 2012; Varcoe et al., 2017). The WEB screening tool can be used to uncover disempowerment and fear as related to IPV (Bonomi et al., 2006b), while Tambling and colleagues (2012) applied the PCEP intervention to sexually empower and educate survivors of violence. In the study by Varcoe and colleagues

(2017), it was noted that the iHEAL intervention led to an increased sense of personal and interpersonal agency.

Links between social or relationship conflicts and the occurrence of victimization were found in three studies. Guruge and colleagues (2012) found that social support leads to positive health benefits for women experiencing IPV, but this impact is diminished by an increase in social conflict. In addition, creating and maintaining close relationships throughout the life-course was associated with less partner and family violence, and strains on relationships were found to cause aggression between partners (Miszkurka et al., 2016). Varcoe and colleagues (2017) found that iHEAL also led to decreased social conflict in the participants' lives.

Lastly, three of the studies found that the dynamics of group interventions had major impacts on the participants, but in different ways. In Knight and colleagues' (2020) study, group members provided social and other means of support to each other which helped lead to a decrease in IPV. The women in Tambling and colleagues' (2012) study also found the group to be supportive in encouraging discussions, leading to more open dialogue with their children and other people in their lives. Alternatively, in Varcoe and colleagues' (2017) study, there was conflict between members of the intervention groups as they wished to have more time to speak; this caused tension, leading the researchers to conclude that smaller groups would be preferable.

Consultation Stage

Following consultation with subject experts, four more tools, which have included older adult populations in validity testing, were identified: B-SAFER (Brief Spousal Assault Form for the Evaluation of Risk), DVSRF (Domestic Violence Supplementary Report Form), ODARA (Ontario Domestic Assault Risk Assessment), and SARA (Spousal Assault Risk Assessment Guide). These risk assessment tools are commonly used by police services and legal systems

in Ontario to evaluate the potential for harmful situations to occur with many having been adapted for use within the province's shelter system (Ontario Association of Interval & Transition Houses [OAITH], 2011). As such, these tools could provide additional utility for service providers screening for IPV among older women. A comprehensive list of the identified screening and intervention tools can be found in Appendix D.

Discussion

Ultimately, the database search process identified 33 different screening and intervention tools that exist to help service providers identify and respond to intimate partner and family violence experienced by older women (55+). An additional four tools, which could also have utility for service providers, were identified through stakeholder consultation. The vast majority of these tools were for screening purposes, with only six being intervention tools; this indicates that service providers have more tools available to help them identify older women experiencing IPV or family violence, as opposed to having the tools necessary to respond to older women's needs.

Research Implications

First, the sheer lack of studies dedicated specifically to older women represents a major gap in the research. Not only did studies fail to include older women in their sample populations, but those that did had many gaps and limitations. Older women were usually described as those in their 60s, and largely excluded women in their 70s and beyond. More studies are needed to examine IPV and family violence in older women in general. This is consistent with other literature reviews that have found older women did not constitute high percentages of study samples in relation to domestic abuse (e.g., Roberto & Hoyt, 2021). In order to accurately study IPV in older women, it is necessary for them to be properly represented in study populations. In addition, few screening and intervention tools have been developed to assess IPV and family

violence in older women. This aligns with conclusions by Nelson and colleagues (2004), who also found that older populations are absent from the development of screening instruments to identify the potential for IPV and family violence victimization. Furthermore, Pathak and colleagues (2019) did not find any Randomized Control Trials (RCTs) examining interventions for women experiencing IPV, and very few studies in their review described older women using any IPV services. Further, older women with cognitive impairments and dementia should be included in future research to demonstrate the ways in which screening and intervention tools can be developed or adapted to accommodate such high-risk individuals (Brijnath et al., 2020; Van Royen et al., 2020). The inclusion of older women of all ages in more research, or ideally, research devoted to IPV and family violence in older women, will help fill this gap.

Second, researchers need to include more representation from diverse groups in their studies. Although half the studies in this review did include some diverse populations, there was still a dearth of studies that examined intersectional identities at particular risk of GBV, including Indigenous women, 2SLGBTQQIA+ individuals, Black and immigrant women, women living with disabilities, and women living in rural or remote communities. This is consistent with other literature that has found most study samples lacking older adults from underrepresented groups, which limits the generalizability of findings (Roberto & Hoyt, 2021). This indicates that researchers need to further examine the intersections of both age and gender alongside class, race, sexuality, ethnicity, disability, Indigeneity, rural locations, etc. This scoping review did not identify any studies that examined disability as it pertains to older women experiencing IPV and family violence. Furthermore, only one study focused on Indigenous women, and only one study was specific to 2SLGBTQQIA+ individuals. There was a small number of studies limited to Black populations or women from different racial/ethnic backgrounds, but overall, the majority of study participants were Caucasian women. This is not representative of high-risk populations, and

future research is needed to make concerted strides towards properly reflecting the full range and realities of intersectionality experienced by older women around the world.

Finally, researchers should continue to examine the effectiveness of using multiple screening or intervention tools in combination. Studies included in this review that investigated two or more tools concurrently often utilized the multiple tools to identify different types of abuse (i.e., physical vs. psychological). In two instances, researchers employed a screening tool to identify domestic violence followed by an intervention tool to respond to women who had been victimized. O'Doherty and colleagues (2014) stated that future research should delve into IPV screening and intervention tools being used in combination to gain a better understanding of the potential for improved wellbeing in the long-term, and this scoping review supports their conclusion. The literature included in this scoping review identified that the WEB, BRFSS, CTS2, AAS, PVS, and WAST were the most commonly used tools on the whole, as well as the tools most commonly studied concurrently with other tools. Future research should continue to test these tools to determine the most effective combination patterns for either multiple screening tools used in tandem, or the adoption of screening and intervention tools used together.

Practice Implications

Due to the discrepancy between the higher number of screening tools and smaller number of intervention tools found, older women experiencing IPV or family violence would benefit from an increase in the availability of intervention tools and through greater utilization by service providers. In particular, tools that also focus on health and social outcomes would likely offer the most effective interventions. For example, this scoping review found that physical and mental health challenges (e.g., injuries, falls, depression, anxiety, substance use, etc.) are frequently present alongside experiences of GBV. This is consistent with Roberto and Hoyt's

(2021) findings that physical and mental health outcomes due to elder abuse are particularly pervasive in older women. Moreover, findings from this scoping review indicate that interventions focusing on social support and different types of empowerment tend to be quite effective. This is supported by Kiani and colleagues' (2021) study, which found that domestic violence interventions involving economic, communication, and community factors empowered women in terms of their economic capability, and these interventions were more effective in reducing violence than those that did not involve economic factors. Kiani and colleagues (2021) also acknowledge that other studies have found social and economic empowerment of women to be effective in reducing IPV, especially those promoting interpersonal communication skills and enhancing self-sufficiency.

Additionally, this scoping review found that group interventions can help to provide women with support networks (e.g., social, economic, etc.), but it should be noted that the size of a group can be a limiting factor. For example, Varcoe and colleagues (2017) heard from a number of women that they would have preferred more time to speak; due to time constraints of group interventions, there was tension caused within the group structure. Therefore, while it is important to acknowledge the value of group interventions, its limitations must also be recognized.

Further to the research implications of using multiple tools in combination, there may be opportunity for service providers to increase the effectiveness of GBV screening and/or intervention through the joint application of two or more tools. This could potentially increase their ability to identify different types of abuse, or more accurately provide individualized interventions and/or referrals that would best reflect each woman's respective needs. Existing literature pertaining to elder abuse has found that assessment tools often lack a clear referral pathway to enact change and that it is unclear whether screening in healthcare settings

increases effective referrals to supportive agencies (O'Doherty et al., 2014; Van Royen et al., 2020). Using screening and intervention tools simultaneously or jointly may help formalize and streamline this referral pathway; however, it would likely require increased education and training to support service providers in familiarizing themselves with these revised tools in order to increase their confidence in administration of the tools (Brijnath et al., 2020). In addition, service providers have noted the importance of building trust and rapport with older adults in order to solicit a disclosure of elder abuse (Brijnath et al., 2020). A consolidated path from screening to intervention could help older women better place their trust in service providers to more effectively meet their needs.

Lastly, it is worth noting that almost half of the studies in this review were conducted in EDs or other primary care settings, possibly suggesting that healthcare practitioners should be routinely screening for IPV. Based on existing literature, this is a controversial topic with different researchers falling on both sides of the debate. For example, in a systematic review by O'Doherty and colleagues (2014), it was concluded that screening all women for IPV in healthcare settings did not lead to improved outcomes, nor was there sufficient evidence to indicate mandatory screening would be beneficial. On the other hand, Alvarez and colleagues' (2017) review maintains that primary care providers have an important role to play in identifying survivors of IPV, while also acknowledging that the lack of organizational support, training opportunities, and personnel are major barriers to the feasibility of mandatory screening protocols. There does not appear to be a consensus within the literature that indicates mandatory screening for GBV in primary care settings would be effective, given the number of structural barriers that still need to be overcome.

Policy Implications

In order to improve service providers' effective use of screening and intervention tools to identify and respond to women experiencing IPV or family violence, policy-makers need to recognize the vast and diverse needs of older women. There is no single solution that can be implemented for every individual's unique situation. If decision-makers enhance the visibility of the issue of late-life GBV, this could have a significant impact by further encouraging research representative of all populations of women (Crockett et al., 2015). This means not only acknowledging older women, but also diverse intersectionalities, such as race, sexuality, Indigeneity, gender identity, ethnicity, disability, cognition, etc. Policies need to comprehensively approach GBV in older women, rooted in the understanding that the experiences of younger women cannot be extrapolated as representative of older women (55+) in either research or practice.

Strengths and Limitations

This scoping review was strengthened by its comprehensive search strategy encompassing six academic, six grey literature databases, and hand searching the reference lists of all articles deemed eligible for inclusion. This search strategy set a wide net to capture an extensive list of documents. Additionally, a Research Librarian provided expert consultation and guidance in formulating research questions and defining search terms and eligibility criteria to enhance the relevance of the search strategy. Reference management software (EndNote 20) was utilized to ensure that the references from all academic databases were properly uploaded to the review management software (Covidence). The screening and selection process was streamlined using Covidence, allowing two members of the research team to independently review articles at both the abstract/title and full-text screening stages. Two authors also independently reviewed all grey literature documents that were deemed eligible for full-text screening.

Moreover, this scoping review has benefitted from the employment of Arksey and O'Malley's (2005) optional sixth stage of their framework, through consultation with stakeholders that were able to provide additional insights into relevant keyword terminology, as well as screening and intervention tools that were not captured by the literature searches. This provided valuable information to the authors and added several tools to the list of those identified through the search strategy.

The main limitation of this scoping review is the lack of French language representation due to the unavailability of a French-speaking author during the planning and search stages of the review process. Both English and French language literature were included in the search criteria; however, only English terms were employed in the search process. As such, one French language article was retrieved and translated into English by an independent researcher, but did not meet the remaining inclusion criteria and was therefore excluded. Subsequently, this independent researcher assisted the authors in performing a supplementary French language literature search, which also did not result in any literature that met the selection criteria. In addition, grey literature searches were limited to the first 100 hits, potentially leading to the unintentional exclusion of some articles. This is to be expected, as a cut-off point had to be established and this limit was chosen based on the standard that had been carried out in a scoping review conducted by Pham and colleagues (2014).

Conclusion

Intimate partner and family violence are more often examined in younger, reproductive aged women with an overall lack of understanding of the existence or effects of domestic violence in older women aged 55 and over. The findings of this review highlight important gaps in the ability of service providers to utilize screening and intervention tools to identify and respond to older women (55+). Most notably, there is a blatant lack of research focused

specifically on older women who experience GBV. In addition, older women with different intersectional identities are further underrepresented in the research, leaving out groups of individuals with unique experiences. Screening and intervention tools could potentially be more effective in identifying older women victimized by IPV and family violence if used concurrently to enhance their breadth in identifying different forms of abuse. Additionally, identifying and treating mental and physical health issues that tend to co-occur with IPV would be beneficial for older women, as would intervention tools that promote social support and social and economic empowerment. Future research should focus on older women of diverse backgrounds to create a stronger foundation to promote changes in practical improvements and bring the issues to the forefront of public policy. Decision-makers and policy advocates should also endeavour to shine a light on the issues faced by older women aged 55 and over experiencing GBV to initiate further research.

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