2024

Improving Screening for Intimate Partner Violence Amongst Older Adults

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IMPROVING SCREENING FOR INTIMATE PARTNER VIOLENCE AMONGST OLDER ADULTS

by

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A thesis submitted in partial fulfillment of the requirements
for the Honors Undergraduate Thesis program in Social Work
in the College of Health Professions and Sciences
and in the Burnett Honors College
at the University of Central Florida
Orlando, Florida

Spring Term
2024

Thesis Chair: Julia O'Connor

ABSTRACT

This systematic literature review was conducted to gather a better understanding of screening for intimate partner violence (IPV) among older adults. IPV affects millions of people every year. Many screenings are conducted with women of reproductive age in medical settings, not older adults. This study focused on ways to improve screenings for older adults by addressing topics including elder abuse and IPV and the lack of resources/knowledge for IPV survivors who are older adults. This study was a literature review conducted with the University of Central Florida's PRIMO database to find articles on IPV among older adults over the last 20 years. The search resulted in 123, with only 14 meeting the criteria, including a focus on older adults, for the results. The results demonstrated ways to improve screening, screening barriers, and information about what should occur after screening, including providing resources to survivors of IPV. The data from this study can be used to help older adults who are experiencing IPV.

TABLE OF CONTENTS

INTRODUCTION

What is Intimate Partner Violence (IPV)?

Intimate Partner Violence (IPV) is any abuse from a current or former partner. The rate of IPV among women is about 22.1%, while about 7.4% of men experienced IPV (Crane et al., 2013). IPV includes physical, sexual, emotional, or economic abuse (Rivas et al., 2019). For example, physical IPV can consist of a person hitting, pushing, or throwing objects at their partner, causing harm to their body in some way (Krigel & Benjamin, 2020). Emotional IPV can be verbal insults, humiliation, and isolation (Beach et al., 2016). Economic IPV is a type of abuse that can affect a victim's ability to use, acquire, and maintain resources (Johnson et al., 2022). IPV can also include stalking, which can lead to injury, medical care, or post-traumatic stress disorder (PTSD) (Miller et al., 2018). These different types of IPV can have negative impacts on the victims.

Impact Of IPV on Survivors

Intimate Partner Violence can significantly affect mental and physical well-being, including reactions to traumatic experiences. When women experience IPV, survivors often hide it, which can cause poorer mental health and well-being (McGarry & Ali, 2016). Those who have experienced IPV report negative thoughts, anxiety, depression, post-traumatic stress disorder, self-harm, and substance abuse (McGarry & Ali, 2016). Additionally, many women may not report IPV to law enforcement due to distrust, fear of reporting, shame, self-blame trying to protect their loved ones, and concern for retaliatory violence (Miller et al., 2018). Physical IPV can cause many injuries such as burns, broken limbs, bruises, and cuts (Gilbert et

al., 2022). Sexual well-being can also be affected by IPV. Being sexually abused has been associated with sexual risk-taking behaviors, sexually transmitted infections, risk of unwanted pregnancy that may result in an induced abortion, and sexual dysfunction in the form of chronic pelvic pain (Coker, 2007).

IPV and Older Adults

For the purpose of this thesis, an older adult is defined as someone 60 years or older (Beach et al., 2016), and older adults can be victims of IPV, no matter their age. Older adults are also at risk of elder abuse. Elder abuse is the act of physical, sexual, or psychological abuse, as well as neglect, abandonment, and financial exploitation caused by another person, such as a caregiver (Beach et al., 2016). For older adults, IPV is often conflated with elder abuse (McGarry & Ali, 2016): elder abuse and IPV can be confused since they both involve aspects of abuse but are inflicted by different perpetrators (caregivers for elder abuse and intimate partners for IPV). For example, if the abuse is perpetrated by a caregiver who is the partner of the older adult, that would technically be considered IPV. There are gaps in evidence when it comes to finding out if older adults have experienced IPV (Meyer et al., 2020). However, if the abusive caregiver is a family member, such as a child, that would be considered elder abuse. That means that the rate of IPV among older women is difficult to measure since it may be reported as elder abuse, not IPV.

Statistics show that a large percentage of older women experience IPV, both physical and non-physical violence, in their lifetime. For older adults, 26.5% of women over 60 experienced IPV in their life (Bonomi et al., 2007). Of these women, 18% experienced physical IPV while 21.9% experienced non-physical violence (Bonomi et al., 2007). For older adults, those who

reported having a controlling partner were 8.5 times more likely to experience physical abuse (Policastro & Finn, 2017).

IPV can impact the health of older adults and may be especially impactful for those who are cognitively impaired (Schreiber & Salivar, 2021). Older adults who have experienced IPV also report joint problems, digestive problems, chronic pain, high blood pressure, or heart problems (Schreiber & Salivar, 2021). Additionally, older women who experienced IPV when younger reported lower well-being during their midlife and a higher prevalence of anxiety and depression (Cations et al., 2021). These women also report anxiety and depression (Schreiber & Salivar, 2021). Older adults who have experienced a traumatic event, have poor health, and have lower social support have an increased chance of experiencing IPV (Policastro & Finn, 2017). Older adults are also more susceptible to harm, may lack employment, have decreased physical ability, are increasingly dependent on family and caregivers, and have declines in support (Band-Winterstein, 2015). These factors may make it difficult for older adults to leave abusive relationships.

Screening

Screening tools allow professionals to intervene and help in IPV situations. Screening measures are questionnaires that are commonly administered to patients during medical appointments to determine if the patient is experiencing adverse outcomes or disease, such as IPV. Healthcare professionals analyze the screener to see if the patient answered any questions that indicate that they have experienced IPV. It is important to have these screenings so those who are experiencing IPV can be identified to access the help and resources they need.

Several different screening instruments are commonly used to assess IPV. HITS (Hurt, Insult, Threaten, Scream) is an instrument that includes four questions and can be self or clinician-administered (Moyer, 2013). OAS/OVAT (Ongoing Abuse Screen/Ongoing Violence Assessment Tool) is a five-item instrument measuring current and past abuse (Moyer, 2013). OVAT is a 4-item version of OAS (Moyer, 2013). STaT (Slapped, Threatened, and Throw) is a three-item self-report instrument evaluated among women in a primary care setting (Moyer, 2013). HARK (Humiliation, Afraid, Rape, and Kick) is a self-administered three-item instrument (Moyer, 2013). WAST (Women Abuse Screen Tool) is a screener that includes eight items that assess physical and emotional IPV (Moyer, 2013). Another tool, the Modified Childhood Trauma Questionnaire-Short Form (CTQ-SF), is used to detect a history of physical or sexual abuse in childhood (Moyer, 2013). These are just some examples of screenings to help identify IPV.

When it comes to IPV, screening is primarily done by healthcare professionals, including mental health nurses (Arkins et al., 2016; Miller et al., 2018). However, some screenings, like the HARK, can be self-administrated by an individual (Moyer, 2013). The setting of screening can vary based on needs. Since some screening measures are self-reported, they can be completed in victims' homes or other locations (Miller et al., 2018). Screenings can also occur in primary care settings (Miller et al., 2018). When older adults are involved, screenings are primarily conducted in long-term facilities or in the home (Beach et al., 2016). Different settings allow victims to be screened in the most comfortable setting but also where screening is possible.

LITERATURE REVIEW

Screening of Older Adults

Screening older adults can be more challenging than screening younger individuals (Beach et al., 2016). For older adults who are impaired, screenings may be administered to caregivers, healthcare providers, or include forensic analysis of bruising patterns (which can be done in extended care facilities as well), or reports from social services providers (Beach et al., 2016). The screening is done by giving questionnaires to caregivers, healthcare providers, or others who have encounters with older adults (Beach et al., 2016).

For older adults who are not cognitively impaired, it is easier to screen them for IPV as they can discuss what is going on and better understand the abuse they are experiencing (Beach et al., 2016). Those who are cognitively impaired are harder to screen since they are at a disadvantage as they may struggle with performing daily activities, memory struggles, confusion, and more (Kiosses et al., 2011). If an older adult is cognitively impaired, often the caregiver is given questionnaires by their doctors or even by the official Adult Protective Services (APS) (Beach et al., 2016). In this way, doctors can better understand if abuse is occurring. However, there is the risk that the caregiver will falsify their responses if they are afraid of being caught if they have perpetrated violence.

When it comes to screening for IPV or elder abuse, self-report measures completed by cognitively impaired people should not be relied upon as a single source for screening. Forensic analysis of bruising patterns may be analyzed, or the screening can be given to the caregiver who may be the perpetrator (Beach et al., 2016). IPV is a serious issue and screening is used to help survivors, ensuring that also includes older adults is important in assisting this population.

Purpose of Study

This study aims to understand how older adults (including those who are cognitively impaired) should be screened for IPV. The specific research question includes: 1) Are there ways to improve IPV screening among older adults? Since there are limitations to screening older adults, addressing this research question can help us have a better understanding of such limitations.

METHODOLOGY

For this study, a systematic literature review was conducted. The literature was pulled from PRIMO and has been published within the last 20 years. The inclusion criteria for the literature include 1) the study will be published between 2003 to 2023, 2) written in English, and 3) peer reviewed. The keywords to be used to search for articles included: *older adults or elders, screening, limitations of screening, IPV or Intimate Partner Violence, IPV amongst older adults, cognitively impaired elders, and accuracy.* The literature was analyzed to address how screening for IPV amongst older adults could be improved. The data was extracted and summarized to address this research question.

RESULTS

A total of 123 articles were found based on the key terms included in the search. Eighty of those articles were excluded based on the title, indicating that these articles did not align with the research question. Two more articles were excluded because they were duplicates. After excluding those, 41 articles remained. When conducting the search for articles on this topic, it became evident that many researchers lumped IPV and elder abuse together when addressing IPV, and others addressed IPV among younger women. After further analysis of the 41 articles, 27 articles were excluded because three were not peer-reviewed articles, four addressed only elder abuse, not IPV, and six investigated younger adults, not older adults. This results in 14 articles included in this review (see Table 1). All 14 articles addressed improving the process of screening for IPV in older adults. These articles did not identify new screeners but instead discussed how screening or identification of IPV among older adults can be improved, the struggles faced when screening for IPV, educating physicians about IPV signs, and what should occur after screening.

Screening is important because those who have experienced IPV need resources to leave the relationship if they wish as well as to address financial and mental struggles (Cations et al., 2021). Additionally, survivors of IPV have higher rates of depression than those who have not experienced IPV, making ongoing support particularly important (Cations et al., 2021). In terms of the legal side of reporting abuse, IPV can sometimes be grouped with elder abuse; however, the legal issues and problems between the two types of abuse are very different (Desmarais & Reeves, 2007). If not properly screened, survivors of IPV might not get all the needed resources (Desmarais & Reeves, 2007). Other obstacles include victim noncooperation, gender, and the relationship status between the perpetrator and victim (Desmarais & Reeves, 2007). Gender was

brought up because it was found that the experience of male victims has received less attention, which is causing a knowledge gap on how to support men along with women (Desmarais & Reeves, 2007). If an older adult is dependent on their partner and lacks cognitive and verbal capacity, this can bring up more legal issues including who will take care of the older adult, who will pay for resources, how will the older adult get around, and more (Desmarais & Reeves, 2007).

Screening for IPV can be a challenge. A variety of barriers come into play when screening for IPV, but screening for IPV among older adults presents its own unique set of additional challenges. IPV can be an especially frightening thing for some older adults to talk about, not because of the abuse alone but, also because they may be dependent on the abusive partner. Some older adults have been with an abusive partner their entire life and might not know life away from them. Or older adults may be uncomfortable speaking about the abuse to a stranger. To help combat the fear and anxiety around disclosing IPV, audio computer-assisted self-interviewing (A-CASI) were developed in one study (Beach et al., 2016). Respondents hear recorded questions through headphones and can respond more privately and freely. This resulted in higher rates of disclosure about financial and psychological abuse that were two to three times higher than when an interviewer asked them (Beach et al., 2016). Along with increased honesty, these interviews were also able to be conducted comfortably from home if the older adults wanted (Beach et al., 2016).

Audio interviews were not the only thing that could improve screening for older adults. Screening for IPV is less commonly conducted within physical checkups as a person ages (Fisher et al., 2011). Instead of asking about IPV, older adults are primarily asked about elder abuse, which can highly lead to inaccurate reports of IPV (Fisher et al., 2011). Similarly, Moyer, (2013)

found that women who are not of reproductive age, primarily older adults, were not asked about IPV. Instead, IPV screening was primarily conducted only among women of reproductive age (Moyer, 2013). Both Fisher (2011) and Moyer (2013) indicate that often IPV is conflated with elder abuse when they are two separate types of abuse with differing interventions for survivors.

Often IPV screenings only occur when there are indications of physical abuse (Fisher et al., 2011). Yet, non-physical abuse is more common among older women compared to physical abuse (Roberto et al., 2013). In two studies of 362 and 842 older adults, 32%-45% of these adults experienced non-physical IPV and stayed with the abusive partner because of a variety of reasons, including financial flexibility, social circles, and dependency on their partners (Roberto et al., 2013). Because the IPV was non-physical and instead emotional/psychological, it was harder to identify with the screening tools which focus on physical IPV (Roberto et al., 2013). This highlights the need to screen for non-physical IPV in addition to physical abuse. Screening for emotional, psychological, and cognitive abuse is extremely important (Fisher et al., 2011), but screenings and the type of questions within these screeners need improvement. According to Freysteinson (2011), one such screening with four questions asks if an older adult was denied access to a wheelchair, cane, walker, etc., and if the individual was denied help with bathing, getting food, taking medication, or even getting dressed, among other questions. These questions help identify non-physical abuse that older adults can experience (Freysteinson, 2011).

To help combat the lack of evidence associated with IPV, physicians need to make sure they are properly documenting signs of abuse (Fisher & Dyer, 2003). If not properly documented, IPV interventions may be delayed due to the lack of evidence (Fisher & Dyer, 2003). If a physician has proper documentation, this can help hold the perpetrator accountable and show proof of IPV (Fisher & Dyer, 2003). In terms of physical abuse, identifying the signs

of it and having a record of physical IPV are important. One way to identify physical abuse is with dental history which can assist in screening older adults for those who are cognitively impaired and cannot talk about IPV or if the older adult is in fear disclosing IPV. About 65-95% of physical abuse occurs to the victim's face (McAndrew & Marin, 2012). If dentists properly document signs of physical abuse to the face, they should report abuse to the authorities and the correct agencies (McAndrew & Marin, 2012). With the proper documentation of dental abuse, the authorities can step in and take the correct steps needed to provide the resources needed for the older adult (McAndrew & Marin, 2012).

To help physicians document IPV better, education on the difference between IPV and elder abuse is important. Screening is not enough to identify and help older adults (Miller et al., 2018). Many physicians might not be trained on the differences between IPV and elder abuse, leading older adult IPV survivors to not receive the help they need (Miller et al., 2018) as the types of interventions for elder abuse and IPV are very different (Fulmer & Bolton, 2004). With elder abuse, healthcare workers, police, and Adult Protective Services (APS) can help older adults (Fulmer & Bolton, 2004). However, with IPV, older adults might need additional referrals to IPV shelters, legal services, and/or peer support groups (Fulmer & Bolton, 2004). IPV and elder abuse are their own categories of abuse and have certain interventions for each type off abuse. Contacting the correct referrals is important for the safety and well-being of the older adult. Thus, education among physicians can also help older adults receive correct referrals, interventions, and support groups (Miller et al., 2018).

Simmons and Baxter (2010) also discuss the importance of educating in-home clinicians on the signs of abuse. In this study, the authors discuss findings from another study, Gutmanis et al., 2007, that sixty percent of physicians and nurses made comments about being uneducated on

what to do in incidents of IPV, the resources available, and only screen for IPV when physical signs are prevalent (Simmons & Baxter, 2010). Likewise, Touza and Segura's (2012) study was done to help social services identify the signs of IPV and neglect, and how to tell the difference. The researchers used the Elder Scale and Alleged Abuser Scale to help score their tool, the EDMA, to see if it could correctly identify abuse, self-neglect, and inappropriate treatment among doctors who knew their patient's cases (Touza & Segura, 2012). The results indicate that the Elder Scale was correct 88% of the time or higher in identifying IPV cases (Touza & Segura, 2012). This tool can help improve screening for IPV, and it can also help further educate physicians by showing physicians what to be on the lookout for. It can also help physicians give out the proper resources/referrals needed for the type of abuse it is. This tool is used to "place" the elders and/or the alleged abusers into treatment (Touza & Segura, 2012). It helped identify the relationship between the older adults and the abusers/themselves (Touza & Segura, 2012). The goal of it was to create the appropriate treatment on one end of the scale and abuse on the other (Touza & Segura, 2012). Since the scales can better identify what type of abuse is occurring, this can help social services and physicians create a proper management plan for these older adults based on the report (Fisher & Dyer, 2003).

Another important component of screening is providing resources to survivors of IPV. Hawkins et al. (2009) discuss a faster method of entering the results from IPV screenings and resulting referrals. A personal digital assistant (PDA) and a personal computer were implemented during home visits within the Home Health Visiting Nurse Association (HHVNAs) with the goal of implementing expediting screenings and resulting IPV interventions (Hawkins et al., 2009). The PDAs and personal computers are encrypted and used to securely transmit data to official agencies for reporting and referrals for survivors, resulting in shortened response time

from reporting to referrals (Hawkins et al., 2009). Thus, the use of technology securely can further help improve screenings and the intervention time of IPV. When it comes to IPV, screening and referral are just the first step. IPV can impact an older adult's life even after they leave the abusive relationship with experiences of trauma. Ongoing support and clinical screening are important for women who have experienced IPV (Cations et al., 2021).

Table 1: Recommendations for Improving Screening for IPV Among Older Adults

Authors	**Improving Screening on IPV in Older Adults**
Beach et al., (2016)	This article mentions conducting audio interviews to make sure older adults respond truthfully. With audio interviews, older adults are more likely to feel comfortable speaking about what is happening. This also allows many older adults to participate in the interviews from the comfort of their home. This can help further improve screenings and the intervention process for IPV survivors.
Cations et al., (2021)	This article discusses that ongoing support and clinical screenings are important for women who have experienced IPV. Importantly, IPV can impact women in later life, not just in the at a younger age.

Desmarais & Reeves, (2007)	This article brings up legal issues facing programs and how IPV and elder abuse are two different things. The legal issues include some obstacles such as lack of physical evidence, victim noncooperation, gender, the relationship status between the perpetrator and victim, etc. Some other legal issues with IPV in older adults are the dependency on the partner and the victim's lack of cognitive and verbal capacity. This is important because the types of screenings for IPV and elder abuse are different. The legal issues within the two can vary depending on the case.
Fisher & Dyer, (2003)	This article states that for physicians it is important to make sure everything is being documented properly so if a caregiver is deceitful, this is evidence of the abuse. Because older adults may have a harder time leaving abusive relationship due to a number of reasons, creating a management plan for these older adults is important. When screening, without documentation, intervention for IPV may but not done correctly and legal evidence may be lost.
Fisher et al., (2011)	This article found a need to increase screening for abuse in older women. It was found that many older women are not asked about IPV, just elder abuse, unless signs of IPV exist.

	Psychological and emotional abuse are more common in older women. This means that when screening for IPV in older adults, physical signs are looked for more than psychological and emotional signs.
Freysteinson, (2011)	This article helps identify a screening tool for physical and cognitive abuse. According to the article, there is a four-question screening for individuals with physical disabilities. It asks questions such as if one has been pushed, if they were not allowed to use their wheelchair, cane, etc and if one was denied help to be bathed, take medication, get dressed, or even help with getting food.
Fulmer & Bolton, (2004)	This study addresses the difference between elder mistreatment or IPV, partnering with those who specialize in IPV can further help address this issue. If clinicians correctly identify if IPV or elder abuse is occurring, they can provide the correct interventions. With elder abuse, referral to health care workers, police, APS, are often utilized. With IPV, referral to shelters, legal services, and peer support groups may also be needed.

Hawkins et al., (2009)	This article addressed how agencies can sustain these different projects over time. The project was a team of Home Health VNAs (HHVNA) looking for ways to use technology to speed up screening and interventions on domestic violence. This was done through nurses who provided in-home care and could screen (an initial risk assessment and follow-up assessment) Personal digital assistants (PDAs) and personal computers were given to these nurses which allowed a quicker response to reporting and referrals than before. These PDAs and computers are used to select, encrypt, and securely transmit data to official agencies for reporting and referrals.
McAndrew & Marin, (2012)	The authors of this study looked at dental histories for signs of physical IPV since 65-95% of abuse is directed at the face. Dentists need to document signs of abuse to keep a history and evidence of IPV. If there are signs of abuse, the dentist will have a record that can be provided to the proper authorities.
Miller et al., (2018)	The authors of this article discuss how older adults struggle with IPV and how screening alone is insufficient to help prevent IPV. More referrals, interventions, education, and assessments are needed to help older adult IPV victims.

Moyer, V. A. (2013)	This study found that many women are not asked about IPV when they are older. This is because evidence shows that IPV is more prominent in women of reproductive age. However, IPV still occurs among older adults and hence, IPV screenings should still be conducted with old adults.
Roberto et al., (2013)	Within this article, two studies of older women found between 32%-45% of them experienced non-physical IPV. Many IPV survivors reported that it was hard to leave the relationship due to financial struggles, flexibility, social circles, and dependency on the abusive partners. The authors recommended that researchers broaden screening for non-physical IPV since psychological IPV can be more difficult to identify as it is "unseen."
Simmons & Baxter, (2010)	The authors of this study suggest that it is important for home clinicians to recognize signs of IPV in older adults and improve screening by educating physicians on IPV. Some physicians stated they were uneducated on what to do, what resources there are, and only screening for IPV when physical signs are prevalent.
Touza & Segura, (2012)	The study was done to help find a useful tool for social service professionals to better identify neglect and IPV among older adults. They used the Elder Scale to see if it could correctly

	identify abuse, self-neglect, and inappropriate treatment. On average, in each test, it was 88% and higher in identifying the cases correctly. Meaning it has a high success rate of correctly identifying what kind of abuse is going on.

DISCUSSION

This study consisted of 14 peer-reviewed articles from the last 20 years examining the literature on how to improve screening for IPV among older adults. The included studies discussed IPV in older adults and ways to improve screening for IPV. A majority of the studies screened out of the literature review lacked information on IPV, specifically among older adults. Overall, the studies included in this literature review discussed methods to improve screening for IPV among older adults. Several focused on screening, while some specified how to conduct more screenings, including audio and in-home screenings.

The 14 articles in this study discussed how screening can be improved for older adults experiencing IPV for both those who are cognitively impaired and those who are not. Suggestions included conducting audio interviews, looking at dental history, screening for emotional and psychological IPV, and further educating in-home clinicians. Some of these articles also made it a point to educate nurses and physicians on the difference between elder abuse and IPV. This review study demonstrates that education on IPV among older adults is limited, indicating that older adults may not know they are experiencing IPV and indicating the importance of education and screening. With additional screening among older adults, education can be included for those who indicate they are experiencing IPV.

The findings from this study can be used as a stepping stone to better improve screening among older adults and differentiate between elder abuse and IPV to ensure proper resources are provided to survivors. Along with that, screening tools need to be updated and made easier for older adults to understand. Audio interviews should be used for those who may feel uncomfortable disclosing to medical providers. Dental history can be used if the older adult is

cognitively impaired. In-home clinicians should receive education on IPV, proper documentation, and resources for IPV referrals. Along with that, clinicians should also use technology when reporting IPV. For example, Hawkins et al. (2009) found a faster method to help report and refer older adults who experience IPV. This method was using a personal digital assistant (PDA) and a personal computer during home visits within the Home Health Virtual Nursing Association (Hawkins et al., 2009). The PDAs and personal computers used securely transfer data to official agencies, which should result in shortened response time from reporting to referrals (Hawkins et al., 2009). Thus, the use of technology can further help improve screenings and the intervention time of IPV.

Many articles screened for this study conflated IPV and elder abuse in older adults leading to fewer articles that could be used within this study. Elder abuse is any abuse conducted by a caregiver, this could be physical, psychological, neglect and even abandonment (Beach et al., 2016). In contrast, IPV is any violence from a current or former partner. This can be physical, financial, economic, sexual, or even emotional abuse (Rivas et al., 2019). Because they are two separate forms of abuse, the resources and referrals are different for both. Additionally, many investigations into IPV were only done with women of reproductive age, not older adults who are over 60. This creates a barrier for these older adults who are experiencing IPV. They may not be screened for IPV which will lead to them not receiving the correct resources. Finally, Simmons and Baxter (2010) found that sixty percent of physicians and nurses made comments about being uneducated on what to do in incidents of IPV, the resources available, and only screening for IPV when physical signs are prevalent. This further prevents older adults from receiving care and recourses needed for IPV.

Limitations

During this study, some limitations arose. The first is that by only using one database, the number of articles included in the study was limited. Secondly, only using certain keywords (e.g., *older adults or elders, screening, limitations of screening, IPV,* etc.*)* also limited the number of articles identified. Thirdly, it was extremely difficult to draw conclusions on what type of screening instruments would be appropriate with older adults. This lack of knowledge further put a barrier on what ways we could improve screening. The screening tools are specifically directed towards women of reproductive age, not older adults. So, finding instruments that work best for older adults would be a need for this community. An example would be how within this study it was found that older adults often deal with more psychological and emotional IPV. However, no screening instruments were founded to improve findings of these types of IPV.

CONCLUSION

Intimate Partner Violence (IPV) is an ongoing concern for women worldwide and can have negative impacts on survivors. In this study, a systematic literature review was conducted on screening for IPV in older adults. This literature review resulted in a few recommendations to improve screening, including looking at dental history, conducting audio interviews, and having in-home clinicians use technology to report and screen for IPV. Additionally, this study points to limitations within the field of research on this topic as well. Many articles conflated IPV and elder abuse. By doing so, individual resources and referrals that may be provided to the survivors of abuse may not be appropriate as elder abuse and IPV are two distinct types of abuse and have different types of associated harms. Along with that, a majority of articles only included women of reproductive age. This further underscores the lack of evidence and support for older adults experiencing IPV. The findings in this study can be used to further improve screenings for older adults who have or are currently experiencing IPV.

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