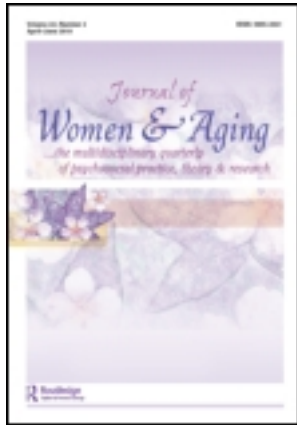


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Intimate Partner Violence in Older Women in Spain: Prevalence, Health Consequences, and Service Utilization

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Intimate Partner Violence in Older Women in Spain: Prevalence, Health Consequences, and Service Utilization

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The purpose of this study is to estimate the prevalence of lifetime intimate partner violence (IPV) in older women and to analyze its effect on women's health and Healthcare Services utilization. Women aged 55 years and over (1,676) randomly sampled from Primary Healthcare Services around Spain were included. Lifetime IPV prevalence, types, and duration were calculated. Descriptive and multivariate procedures using logistic and multiple lineal regression models were used. Of the women studied, 29.4% experienced IPV with an average duration of 21 years. Regardless of the type of IPV experienced, abused women showed significantly poorer health and higher healthcare services utilization compared to women who had never been abused. The high prevalence detected long standing duration, negative health impact, and

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high healthcare services utilization, calling attention to a need for increased efforts aimed at addressing IPV in older women.

KEYWORDS intimate partner violence, age, women's health, healthcare utilization

INTRODUCTION

There has been an increasing awareness of elder abuse as a serious social problem over the last 10 to 20 years, with detrimental health effects for victims (Schofield & Mishra, 2004). Until recently, information regarding violence against older women by an intimate partner was gathered from research conducted on elder abuse (Fisher et al., 2003) whereby most of those previous studies did not clearly distinguish abuse perpetrated by spouses from abuse perpetrated by significant others, such as relatives or caregivers (Lachs & Pillemer, 1995). The most common type of violence against women is intimate partner violence (IPV), which refers to any behavior within an intimate relationship that causes physical, psychological, or sexual harm to those in the relationship (World Health Organization [WHO], 2002). A previous large-population study on elder abuse found that 59% of the perpetrators were spouses (Pillemer & Finkelhor, 1988) and another study carried out on services for victim protection revealed that 56% of adult victims of violence were women over 65 years of age, indicating that in 30% of the cases the perpetrator was an intimate partner (Teaster, 2000).

At the beginning of 2000, a growing body of research focused on the violence perpetrated by an intimate partner in older women (Mouton et al., 2004; Fritsch, Tarima, Caldwell, & Beaven, 2005; Bonomi et al., 2007). Findings of a previous study concluded that the risk of IPV is higher in younger women (aged 20 to 30) and tends to decline with age (Rivara et al., 2009). Other studies, however, found that women experienced significantly more threats and physical mistreatment from the age of 55 (Zink & Fisher, 2006). A study among women over 55 found that physical and sexual IPV is less frequent in older than in younger women (Zink, Fisher, Regan, & Pabst, 2005), while another study revealed that the frequency among women over 65 is similar to the frequency detected among younger women (Bonomi et al., 2007). Those contradictions may be explained by the definition of violence and how this violence has been assessed, the culture, age distribution of the population studied, length of the observation period, and the sampling extraction methodology used (Ruiz-Pérez, Plazaola-Castaño, & Vives-Cases, 2007).

Currently, there is no doubt that women with any past or recent history of violence present worse health outcomes (Campbell, 2002; Ellsberg et al.,

2008; Montero et al., 2011) and show a greater use of healthcare services than those women with no history of IPV (Rivara et al., 2007; Bonomi, Anderson, Rivara, & Thompson, 2009). Although violence by an intimate partner is more frequent against “younger” elderly than women of a more advanced age (Moraes, Apratto Júnior, & Reichenheim, 2008), literature about health consequences of violence in older people is mainly focused on women of more advanced ages, specifically in women over age 65 (Cooper, Selwood, & Livingston, 2008).

Scarcely research has addressed the broader health implications of violence by an intimate partner in middle-aged and “younger” older women. Moreover, as most of the studies come from English speaking countries, even less is known about the IPV experience among women aged 55 and older living in Mediterranean countries. In an aging society where Spanish women have a life expectancy of 85 years (Instituto Nacional de Estadística [INE], 2010) and where a significant number of older women have experienced violence by a partner, studying the impact of IPV on health and health services utilization seems to be of particular interest, given the potential for social isolation and functional impairments (Shugarman, Fries, Wolf, & Morris, 2003).

This study aims to: (a) estimate the lifetime prevalence of IPV, its typology, and duration among Spanish women aged 55 to 70 attending primary healthcare centres for any reason; (b) analyze the effect of physical and psychological IPV and duration on women’s health; (c) assess the effects of physical and psychological IPV and the duration of the violent relationship over the utilization of healthcare services.

METHODS

Data Source

This study used data from a national cross-sectional survey of adult women recruited during 2006–2007 from female patients seeking medical care for whatever reason in primary care services around the country (Ruiz-Pérez et al., 2010). The number of women invited to participate was 16,419, with a decline percentage of 27%. Women were excluded from the study if they were illiterate, did not understand Spanish, or had severe cognitive disabilities that impaired the completion of a written questionnaire. According to the ethical and safety recommendations for research on domestic violence against women (WHO, 1999), females who attended the practice with a male partner were also excluded.

After excluding 1,153 questionnaires by women who reported never having had an intimate male partner and an additional 467 incomplete questionnaires, the final group comprised 10,322 women. As there has been a paucity of research on the experiences of victimization among “younger”

elderly, we selected women aged 55 to 70 and a final sample of 1,676 women was included in the present study.

Procedure and Data Collection

Women meeting the eligibility criteria were invited by the physician to participate after their medical consultation had finished. If they gave informed consent for participation, a self-administered questionnaire was given in an envelope which also contained information on available community resources for battered women in the area. Both confidentiality and anonymity were guaranteed at all times. This study was coordinated by six research groups across Spain and was approved by the Ethics Committee of each of the participating groups.

Variables

RELATED TO IPV

Women were asked if any male intimate partner (spouses, non-marital partners, former marital partners, and former non-marital partners) had abused them physically (hit, slapped, kicked, pushed, etc.), psychologically (threatened, insulted, humiliated, been extremely jealous, scared them, etc.), or sexually (forced them to have intercourse against their will) during their adult life. These three questions were used in previous studies showing high comprehensibility and acceptability (Ruiz-Pérez et al., 2006). If women reported any of the aforementioned types of abuse had occurred “sometimes” or “many times,” they were asked the number of years they experienced partner violence during their adult lifetime. Lifetime IPV was categorized as physical only (physical and/or sexual), psychological only (threats or controlling behavior), or both physical and psychological IPV.

HEALTH INDICATORS

Four health indicators were selected based on literature that examined the long-term negative consequences of violence: psychological distress, somatic complaints, use of tranquilizers and/or antidepressants, and use of analgesics.

Psychological distress. This was measured by the General Health Questionnaire (GHQ-12) which has been internationally validated (Duncan-Jones, 1979), and has been used extensively with women and in studies which analyze the consequences of violence in women’s health (Romito, Molzan, & De Marchi, 2005). The scale considers anxiety, depression, and self-esteem as experienced in the last month and contains 12 items with 4 possible responses. It provides a final continuous score between 0 and

12, and scores equal to or above 3 indicate the presence of psychological distress (Lobo & Muñoz, 1996).

Somatic complaints. The following physical health problems over the last twelve months were explored: headaches, migraines; kidney or urinary complaints; gastrointestinal disorders; neck, shoulder, or back pain; and menstrual and gynaecological problems. Somatic complaints were dichotomized into two categories: 0 = no somatic complaints, 1 = one or more somatic complaints.

Use of medication. Self-reported use of tranquilizers and/or antidepressants and analgesics over the last twelve months was recorded.

HEALTHCARE UTILIZATION

We determined women's healthcare services utilization during a six-month period including primary care, specialists' services, emergency room visits, and hospital admissions. If any of these health services were used, women were asked for the frequency over the last six months. Taking into account the selection strategy used, all women reported at least one primary care appointment. Hospital admission was taken into consideration if a woman occupied a hospital bed regardless of the number of days of hospitalization.

Adjusting Variables

Previous studies have shown a relationship between IPV and several socio-demographic factors, such as age, marital status, education, native country, monthly family income, and social support (Romito, Molzan, & De Marchin, 2005; Ruiz-Pérez et al., 2006; Romans, Forte, Cohen, Du Mont, & Hyman, 2007). Social support was measured by a question that appraised the availability of specific help for a particular situation (Blake & McKay, 1986), for example, "How many people can you really turn to when you have a problem or difficulty?" Answers were coded as a dichotomous variable of value 0 = *no* ("no one to turn to for support"); 1 = *yes* ("one person or more"). Therefore, these variables were considered in the analysis as potential confounders.

Statistical Analysis

We estimated lifetime prevalence of IPV, the frequency of each abuse type (physical, sexual, and psychological), and the proportion of women that reported more than one type of abuse. The Chi-square test was used to investigate possible differences between abused women and women who were never abused. Given the low number of women that experienced exclusively sexual or physical IPV, we grouped both types as physical IPV. Also, women who reported more than one type of abuse were grouped as "both" (physical and psychological). First, we calculated the health impact in midlife

and older women of any lifetime IPV, performing the analysis by type (physical, psychological, and both) and years of duration. A logistic regression model was fitted for each outcome variable. Odds ratios (OR) were adjusted for potential confounding factors. In order to assess the incremental prediction of each use of health services that could be attributed statistically to the types and duration of IPV, multiple linear regression models were conducted. All models were analyzed using SPSS Version 18.0 and all data analyses were performed in 2011.

RESULTS

Approximately 50% of abused women were 55 to 59 years old and 20.3% were above 65. Compared to non-abused women, those who experienced any history of abuse were more likely to be separated or divorced at the time of the study, had lower household incomes, less social support, and a larger proportion of them were not Spanish nationals (Table 1).

The prevalence of lifetime IPV, type and years of exposure are shown in Table 2. The percentage of women who reported IPV of any type (physical, sexual, and psychological) in their lifetime was 29.4%. Of those, 13.7% reported more than one type of IPV (5.2% two types and 8.5% three types). Psychological IPV only was more frequent (9.0%) among victims than physical IPV only (2.7%), or sexual IPV only (2.4%). The long duration of the violent relationship should be highlighted, lasting an average of 21 years, with 6.4% of the women reporting abuse lasting more than 20 years. Women 55 and older with a history of violence reported significantly poorer physical and mental health and higher use of medication than women with no such history. The impact was higher for women who reported a combination of physical and psychological IPV, especially for psychological distress (OR = 3.49, 2.35–5.19) and use of tranquilizers and/or antidepressant medication (OR = 2.24, 1.49–3.38). While women who reported psychological IPV only were nearly three times more likely to report psychological distress (OR = 2.94, 1.97–4.38), women who reported physical IPV only were three times more likely to report somatic complaints than women who were never abused, although for physical IPV, data did not reach statistical significance (OR = 3.17, 0.88–11.3). The likelihood to use tranquilizers and/or antidepressants is increased 1.02 times for each year of abuse suffered by a woman as compared to women who had never been abused (Table 3). Women with any history of IPV showed a positive correlation between IPV and the number of visits to primary care services. For women who reported a combination of physical and psychological IPV, the probability of increasing the number of visits to primary healthcare services was statistically significant ($\beta = .07$). Women who reported psychological IPV, without physical or sexual IPV, increased the number of visits to primary care centres ($\beta =$

TABLE 1 Socio-demographics Characteristics Among Women who Reported Lifetime IPV and Women who did not (n = 1,676)

Characteristics	No Lifetime IPV (n = 1,184)	Lifetime IPV (n = 492)	P-Value
	n (%)	n (%)	
Age (years)			.07
55-59 years	515 (43.5)	241 (49.0)	
60-64 years	378 (31.9)	151 (30.8)	
65-70 years	291 (24.6)	100 (20.3)	
Marital status			<.001
Married	1,005 (85.0)	312 (63.4)	
Unmarried	24 (2.0)	3 (0.7)	
Separated/Divorced	37 (3.1)	127 (25.7)	
Widowed	116 (9.8)	50 (10.2)	
Children			.81
No	609 (52.7)	255 (53.3)	
Yes	546 (47.3)	223 (46.7)	
Employment status			<.001
Housewife	642 (54.8)	212 (43.2)	
Employed	325 (27.8)	179 (36.4)	
Retired	205 (17.5)	100 (20.4)	
Education			.11
Primary	711 (60.9)	286 (58.8)	
Secondary	274 (23.5)	136 (27.9)	
University degree	183 (15.6)	65 (13.3)	
Monthly income (\$)			<.001
≤1,200	317 (28.8)	201 (42.6)	
1,201–2,500	549 (49.8)	207 (43.8)	
>2,500	236 (21.4)	64 (13.6)	
Social support			<.001
No	19 (2.0)	28 (6.5)	
Yes	939 (98.0)	406 (93.5)	
Native country			<.001
Spain	1,160 (98.5)	465 (94.7)	
Other	17 (1.5)	26 (5.3)	

Note. IPV = intimate partner violence.

.11) and emergency rooms ($\beta = .13$). The number of visits to specialist services increased with the number of years women were exposed to the violence relationship ($\beta = .27$; Table 4).

DISCUSSION

The findings of this study show that nearly 30% of female Spanish patients aged 55 years and over attending primary healthcare services have experienced some type of IPV during adulthood, and in a large proportion of them, this abuse persisted for more than 20 years. The estimated prevalence in our study with “younger” older women is higher than that calculated in a previous study with a representative sample of Spanish adult women ages

TABLE 2 Prevalence, Types and Duration of IPV for Midlife and Older Women (n = 1,676)

	n (%)
No lifetime IPV	1,184 (70.6)
Lifetime IPV ^a	492 (29.4)
Type	
Physical only	46 (2.7)
Sexual only	41 (2.4)
Psychological only	149 (9.0)
Physical + Psychological	35 (2.0)
Physical + Sexual	3 (0.1)
Sexual + Psychological	53 (3.1)
Physical + Sexual + Psychological	143 (8.5)
Duration (years)	
<10 years	250 (14.9)
11–20 years	58 (3.5)
21–30 years	45 (2.7)
>30 years	62 (3.7)
Mean (SD)	21.2 (13.2)

^aMissing values.

IPV = intimate partner violence.

SD = standard deviation.

TABLE 3 Health Outcomes in Midlife and Older Women who Reported Lifetime IPV^a

	Psychological distress ^b	Somatic Complaints ^c	Use of tranquilizers and/or antidepressant ^d	Use of analgesic medication ^d
	OR (95% CI)	OR (95% CI)	OR (95% CI)	OR (95% CI)
Lifetime IPV	2.98** (2.27–3.91)	2.03* (1.21–3.41)	2.27** (1.75–2.94)	1.68** (1.27–2.22)
Physical (physical or sexual) only	1.93* (1.14–3.28)	3.17 (0.88–11.3)	1.42 (0.85–2.38)	1.13 (0.68–1.88)
Psychological only	2.94** (1.97–4.38)	1.86 (0.88–3.93)	1.73* (1.18–2.52)	1.70* (1.12–2.58)
Both (physical and psychological)	3.49** (2.40–5.06)	1.78 (0.89–3.55)	3.26** (2.29–4.65)	1.99* (1.34–2.94)
Duration of IPV (years)	0.99 (0.96–1.02)	1.05 (0.99–1.11)	1.02* (1.00–1.05)	1.01 (0.99–1.04)

Note. No lifetime IPV reference group for all analyses.

^aAll models were adjusted for marital status, education, monthly household income, tangible social support and native country.

*p-value < .05; **p-value < .001.

IPV = intimate partner violence. OR = Odds ratios. CI = confidence interval.

18 to 70 (24%; Ruiz-Pérez et al., 2010). This prevalence suggested that IPV not only may occur throughout a woman's lifetime, but also can increase with age.

Compared to previous studies in older women, our estimated prevalence is similar (26.5%) to that found in women aged 65 and older (Bonomi et al., 2007). However, this rate is lower than one prior lifetime IPV estimate

TABLE 4 Use of Health Care Services by Midlife and Older who Reported Lifetime IPV^a

	Primary Care Services	Specialist services	Emergency Rooms	Hospital Admissions
	β (R ²)	β (R ²)	β (R ²)	β (R ²)
Lifetime IPV	.09* (.05)	.01 (.01)	.10 (.05)	.02 (.02)
Physical (physical or sexual) only	.01 (.04)	.01 (.01)	.08 (.07)	.13 (.02)
Psychological only	.11** (.06)	.01 (.01)	.13* (.10)	.06 (.01)
Both (physical and psychological)	.07* (.04)	.01 (.01)	.04 (.04)	.12 (.06)
Duration of IPV (years)	.08 (.09)	.27* (.22)	.11 (.41)	.10 (.41)

^aAll models were adjusted for marital status, education, monthly household income, tangible social support, and native country.

*p-value < .05; **p-value < .001.

IPV = intimate partner violence. β = Beta, standardized coefficients. R² the proportion of the variance explained by the model.

of 35.5% in women aged 50 to 56 (Jones et al., 1999), and it is higher than one prior estimate of 18.1% in older women (Teaster, 2000). This wide range of figures, also documented by studies not focused on older women (Garcia-Moreno et al., 2006), could be explained because studies employed different population ages, measures, and definitions of IPV.

This study also confirms that in older women, psychological abuse is more frequent than physical (physical and sexual) abuse, although our estimates are lower than those found in a previous study where 18.4% of women experienced physical violence and 21.9% experienced non-physical violence (Bonomi et al., 2007). A possible explanation for such variation could be that in our case both IPV types (physical and psychological) have been accounted for as an excluding category. On the other hand, in a study with women aged 55 and older who attended primary healthcare services, the estimates were lower: 3.6% for physical and sexual IPV and 2.6% for psychological IPV, although it must be pointed out that exposure to IPV was estimated from 55 years old and onwards (Zink et al., 2005).

Women with more than one type of IPV presented more pronounced adverse health effects than women who experienced physical or psychological IPV only. This result is congruent with prior studies which found that the magnitude of the relationship between IPV and an adverse health status rises as the number of violence types increases (Mcnutt, Carlson, Persaud, & Postmus, 2002). Taking the nature of the aggressions which characterize both types of IPV into consideration, it seems plausible that attitudes such as humiliation, threats, or controlling behavior are more likely to affect psychological wellbeing, while behaviors such as hitting, pushing, kicking, or forced sexual intercourse may be related to a greater probability of chronic health problems. Likewise, the activation of a physiological response to situations of severe stress and consequences of the physical and sexual aggression may

explain in part the high frequency of somatic complaints in women who suffer physical IPV (physical and sexual; Campbell et al., 2002).

Violence was positively correlated to primary healthcare services utilization, especially for women who experienced a combination of different types of abuse and for women who experienced psychological IPV only. Literature documents that enduring psychological abuse is a much stronger predictor of fear than physical abuse (Baker et al., 2009) and it is associated with poorer physical and mental health, as well as a limitation in social functioning (Shugarman et al., 2003). These negative health consequences could explain why women with long lasting psychological IPV are higher users of the most accessible services such as primary healthcare and emergency rooms.

Our study shows that, as the length of exposure to IPV increases, so does the frequency of use of specialist services, which in our case included mental health services. Moreover, the use of tranquilizers and/or antidepressants was positively correlated to length of IPV. As abuse persists over time, women's mental health may be affected by several emotional responses such as hopelessness and low self-esteem, constituting emotional barriers which impede them from ending the violent relationship. (Beaulaurier, Seff, & Newman, 2008; Montero et al., 2010).

Clinical and Policy Implications

The prevalence of chronic diseases in older adults, chronic physical complaints (including pain), or indicators of depression and anxiety, as well as higher use of healthcare services, should elicit focused inquiries about possible abuse. Providers, especially general practitioners, are encouraged to identify signals of potential abuse and must consider the generational values held by older IPV victims and understand how those values may impact decision making. For abused older women, it should be a priority to implement gender empowerment measures as well as to strengthen financial and community support.

Limitations

Despite methodological constraints, this study provides the first set of information about the prevalence of IPV and its consequences related to the health of Spanish women aged 55 years and over. Given that this study was restricted to women aged 55 to 70, the extent to which these findings can be generalized to older women is unknown. By excluding women who attended primary healthcare services accompanied by a male partner, we may have left out an undetermined number of women exposed to greater control and abuse by their current partners than those who attended alone. Due to the association found in previous studies between IPV and low socioeconomic indicators and seeing that participants in our study were asked

to complete a written questionnaire, illiterate women were excluded. The exclusion of these women could lead to a selection bias, and the odds ratio could therefore be even higher than that found. The use of self-report can also challenge validity; however, women tend to underreport IPV experiences, especially older women (Garre-Olmo et al., 2009). In Spain, where the family plays a very important role, failure to report domestic violence in our sample may be even greater, which would mean that the non-IPV group in the study included some women who had experienced IPV. Thus, the observed differences in health status and service utilization between those who experienced IPV and those who did not were conservative estimates. The healthcare system in Spain, which is both widely available and accessible to the entire population, may possibly generate a healthcare services use pattern that cannot be generalized to healthcare systems with a different design.

Conclusion

Our results confirm that a large proportion of women aged 55 years and older have experienced violence by an intimate partner during their adult lifetime. The high estimate prevalence, long standing duration, negative health consequences, and the high healthcare service utilization detected, represent a considerable burden for services providers. Clinicians should consider that, in later life, abusers are also intimate partners and not only family members and caregivers. Further studies focused on the health consequences of the various types of abuse are needed to better identify the symptoms and health problems in older women, including cognitive and physical function.

REFERENCES

- Baker, M. W., LaCroix, A. Z., Wu, C., Cochrane, B. B., Wallace, R., & Woods N. F. (2009). Mortality risk associated with physical and verbal abuse in women aged 50 to 79. *Journal of American Geriatrics Society*, *57*(10), 1799–1809.
- Blake, R. L., & McKay, D. A. (1986). A single-item measure of social support as a predictor of morbidity. *The Journal of Family Practice*, *22*(1), 82–84.
- Beaulaurier, R. L., Seff, L. R., & Newman, F. L. (2008). Barriers to help-seeking for older women who experience intimate partner violence: A descriptive model. *Journal of Women & Aging*, *20*(3/4), 231–248.
- Bonomi, A. E., Anderson, M. L., Reid, R. J., Carrell, D., Fishman, P. A., Rivara, F. P., & Thompson, R. S. (2007). Intimate partner violence in older women. *The Gerontologist*, *47*(1), 34–41.
- Bonomi, A. E., Anderson, M. L., Rivara, F. P., & Thompson, R. S. (2009). Health care utilization and cost associated with physical and non-physical-only intimate partner violence. *Health Services Research*, *44*(3), 1052–1067.

- Campbell, C. J. (2002). Health consequences of intimate partner violence. *Lancet*, 359(9314), 1331–1336.
- Campbell, J., Jones, A. S., Dienemann, J., Kub, J., Schollenberger, J., O'Campo, P., Gielen, A. C., & Wynne, C. (2002). Intimate partner violence and physical health consequences. *Archives of Internal Medicine*, 162(10), 1157–1163.
- Cooper, C., Selwood, A., & Livingston, G. (2008). The prevalence of elder abuse and neglect: A systematic review. *Age and Ageing*, 37(2), 151–160.
- Duncan-Jones, P. (1979). Validity and uses of the GHQ. *The British Journal of Psychiatry*, 135, 382.
- Ellsberg, M., Jansen, H. A., Heise, L., Watts, C. H., Garcia-Moreno, C., Campbell, J., Gillioz, L., Jewkes, R., Josiah, I., Meirik, O., Rodrigues, L. C., Saucedo, I., Schei, B., & Wall, S. (2008). Intimate partner violence and women's physical and mental health in the WHO multi-country study on women's health and domestic violence: An observational study. *Lancet*, 371(9619), 1165–1172.
- Fisher, B., Zink, T., Rinto, B., Regan, S., Pabst, S., & Gothelf, E. (2003). Overlooked issues during the golden years: Domestic violence and intimate partner violence against older women. *Violence Against Women*, 9(12), 1409–1416.
- Fritsch, T. A., Tarima, S. S., Caldwell, G. G., & Beaven, S. (2005). Intimate partner violence against older women in Kentucky. *The Journal of the Kentucky Medical Association*, 103(9), 461–463.
- Garcia-Moreno, C., Jansen, H. A., Ellsberg, M., Heise, L., & Watts, C. H. (2006). Prevalence of intimate partner violence: Findings from the WHO multi-country study on women's health and domestic violence. *Lancet*, 368(9543), 1260–1269.
- Garre-Olmo, J., Planas, X., Lopez, S., Juvinya, D., Vila, A., & Vilalta, J. (2009). Prevalence and Risk Factors of Suspected Elder Abuse Subtypes in People Aged 75 and Older [on behalf of the Frailty and Dependence in Girona Study Group]. *Journal of American Geriatric Society*, 57(5), 815–822.
- Instituto Nacional de Estadística (INE). (2010). INEbase Indicadores demográficos básicos [Basic demographic indicators]. Retrieved from http://www.ine.es/inebmenu/mnu_analisis.htm
- Jones, A. S., Gielen, A. C., Campbell, J. C., Schollenberger, J., Dienemann, J. A., Kub, J., O'Campo, P. J., & Wynne, E. C. (1999). Annual and lifetime prevalence of partner abuse in a sample of female HMO enrollees. *Women's Health Issues*, 9(6), 295–305.
- Lachs, M. S., & Pillemer, K. (1995). Abuse and neglect of the elderly persons. *The New England Journal of Medicine*, 332(7), 437–443.
- Lobo, A., & Muñoz, P. (1996). *General Health Questionnaire. Guide to users of different versions. Spanish versions of GHQ*. Barcelona: Masson.
- McNutt, L. A., Carlson, B. E., Persaud, M., & Postmus, J. (2002). Cumulative abuse experiences, physical health and health behaviors. *Annals of Epidemiology*, 12(2), 123–130.
- Montero, I., Ruiz-Pérez, I., Escribà-Agüir, V., Vives-Cases, C., Plazaola-Castaño, J., Talavera, M., Martín-Baena, D., & Peiró, R. (2010). Strategic responses to intimate partner violence against women in Spain: A national study in primary care. *Journal of Epidemiology & Community Health*, 66(4), 352–358.
- Montero, I., Escriba, V., Ruiz-Perez, I., Vives-Cases, C., Martín-Baena, D., Talavera, M., & Plazaola, J. (2011). Interpersonal violence and women's psychological well-being. *Journal of Women's Health*, 20(2), 295–301.

- Moraes, C. L., Apratto Júnior, P. C., & Reichenheim, M. E. (2008). Breaking silence and its barriers: A household survey on domestic violence against the elderly within the scope of a family health program in Niterói, Rio de Janeiro State, Brazil. *Cadernos de Saude Publica*, *24*(10), 2289–2300.
- Mouton, C. P., Rodabough, R. J., Rovi, S. L., Hunt, J. L., Talamantes, M. A., Brzyski, R. G., & Burge, S. K. (2004). Prevalence and 3-year incidence of abuse among postmenopausal women. *American Journal of Public Health*, *94*(4), 605–612.
- Pillemer, K., & Finkelhor, D. (1988). The prevalence of elder abuse: a random sample survey. *Gerontologist*, *28*(1), 51–57.
- Rivara, F. P., Anderson, M. L., Fishman, P., Bonomi, A. E., Reid, R. J., Carrell, D., & Thompson, R. S. (2007). Healthcare utilization and costs for women with a history of intimate partner violence. *American Journal of Preventive Medicine*, *32*(2), 89–96.
- Rivara, F. P., Anderson, M. L., Fishman, P., Reid, R. J., Bonomi, A. E., Carrell, D., & Thompson, R. S. (2009). Age, period, and cohort effects on intimate partner violence. *Violence and Victims*, *24*(5), 627–638.
- Romans, S., Forte, T., Cohen, M. M., Du Mont, J., & Hyman, I. (2007). Who is most at risk for intimate? A Canadian population-based study. *Journal of Interpersonal Violence*, *22*(12), 1495–1514.
- Romito, P., Molzan Turan, J., & De Marchi, M. (2005). The impact of current and past interpersonal violence on women's mental health. *Social Science & Medicine*, *60*(8), 1717–1727.
- Ruiz-Pérez, I., Plazaola-Castaño, J., Alvarez-Kindelán, M., Palomo-Pinto, M., Arnalte-Barrera, M., Bonet-Pla, A., De Santiago-Hernando, M. L., Herranz-Torrubiano, A., Garralón-Ruiz, L. M., & Gender Violence Study Group. (2006). Sociodemographic associations of physical, emotional, and sexual intimate partner violence in Spanish women. *Annals of Epidemiology*, *16*(5), 357–363.
- Ruiz-Pérez, I., Plazaola-Castaño, J., & Vives-Cases, C. (2007). Methodological issues in the study of violence against women. *Journal of Epidemiology & Community Health*, *61*(2), 26–31.
- Ruiz-Pérez, I., Plazaola-Castaño, J., Vives-Cases, C., Montero-Piñar, I., Escribà-Agüir, V., Jiménez-Gutiérrez, E., Martín-Baena, D., & G6 para el Estudio de la Violencia de Género en España. (2010). Variabilidad geográfica de la violencia contra la mujer en España [Geographical variability in violence against women in Spain]. *Gaceta Sanitaria*, *24*(2), 128–135.
- Schofield, M. J., & Mishra, G. D. (2004). Three year health outcomes among older women at risk of elder abuse: Women's Health Australia. *Quality of Life Research*, *13*(6), 1043–1052.
- Shugarman, L. R., Fries, B. E., Wolf, R. S., & Morris, J. N. (2003). Identifying older people at risk of abuse during routine screening practices. *Journal of the American Geriatrics Society*, *51*(1), 24–31.
- Teaster, P. B. (2000). A response to the abuse of vulnerable adults: The 2000 Survey of State Adult Protective Services. Washington, D.C.: The National Center on Elder Abuse. Retrieved from http://www.ncea.aoa.gov/ncearoot/main_site/pdf/research/apsreport030703.pdf
- World Health Organization (WHO). (1999). Putting women's safety first: ethical and safety recommendations for research on domestic violence against women. In *Global Programme on Evidence for Health Policy*. Geneva, Switzerland: Author.

- World Health Organization (WHO). (2002). Missing voices: views of older persons on elder abuse. A study from eight countries: Argentina, Austria, Brazil, Canada, India, Kenya, Lebanon and Sweden. Retrieved from http://whqlibdoc.who.int/hq/2002/WHO_NMH_VIP_02.1.pdf
- Zink, T., Fisher, B. S., Regan, S., & Pabst, S. (2005). The Prevalence and Incidence of Intimate Partner Violence in Older Women in Primary Care Practices. *Journal of General Internal Medicine*, *20*(10), 884–888.
- Zink, T., & Fisher, B. S. (2006). The prevalence and incidence of intimate partner and interpersonal mistreatment in older women in primary care offices. *Journal of Elder Abuse & Neglect*, *18*(1), 83–105.