

Domestic Violence in Later Life: An Overview for Health Care Providers

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SUMMARY. Domestic violence is a significant problem that adversely affects the health and safety of millions of women throughout their life-span. Most cases of what is considered elder abuse occurs at home rather than in institutions, and the evidence suggests that only 1 in 5 cases are recognized. Frequently the perpetrator is a spouse, adult child, or other family member. Given the demographics of aging women and their longer life expectancies, clinicians are increasingly likely to see patients whose injuries or poor health status are caused or affected by abusive relationships. Improving the ability of physicians to identify domestic violence is an important skill needed for establishing comprehensive intervention and prevention efforts. In addition to conducting universal screening of all female patients, using clinical and behavioral indicators is a critical component of the intervention. [Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <getinfo@haworthpressinc.com> Website: <<http://www.HaworthPress.com>> © 2002 by The Haworth Press, Inc. All rights reserved.]

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Elder abuse is a growing but often hidden problem in the United States. It is estimated that only one in five cases of elder abuse is reported. During the ten year period between 1986 and 1996, reported cases of domestic elder abuse increased 150 percent with more than 450,000 older individuals abused or neglected in domestic settings annually. About 90 percent of elder abuse cases are perpetrated by people known to the victim. Two-thirds of these known perpetrators were adult children or spouses. This form of abuse is often referred to as domestic elder abuse or family violence in later life (National Center on Elder Abuse 1998).

As of 1998 there were more than 45 million individuals 60 years of age or older (U.S. Bureau of the Census 1998). During the next several decades, the United States will witness a dramatic increase both in the number of elderly persons and in the proportion of elderly persons in the general population (Siegel 1996). Currently persons age 65 or older comprise 12.6% of the population; in 2040, one in five Americans or 20.5% of the population will be age 65 or older (Administration on Aging 2000), with more females than males.

Since elderly victims regularly use the health care system and older battered women may seek medical treatment for physical injuries that occurred during an assault, for psychosomatic complaints such as nervousness, gastrointestinal problems or headaches, or for depression, anxiety and symptoms of post-traumatic stress disorder (PTSD), health care providers are in a unique position to identify elder domestic abuse, intervene, and provide appropriate referrals. Early identification and intervention can improve the quality of life for older victims and may reduce their reliance on health care services. Addressing the root of the patient's problem, rather than solely treating the presenting symptoms, can save health care providers time and health care costs. This article will identify common presentations of abuse in later life and provide guidance on appropriate intervention.

**DEFINITIONS AND DYNAMICS OF ELDER ABUSE
AND DOMESTIC VIOLENCE IN LATER LIFE**

State law defines the elderly and the recognized forms of elder abuse. Most states define elderly as age 60 or 65 and older, but some states include elder abuse in laws that address abuse against vulnerable adults, who are generally defined as persons with physical and/or cognitive difficulties that limit their ability to protect themselves (Administration on

Aging 2000). Legally, elder abuse generally includes physical and sexual abuse, financial exploitation, neglect and self-neglect. (We do not consider self-neglect here.) These forms of abuse are often accompanied by emotional abuse, e.g., threats, coercion, and isolation. Table 1 contains commonly used definitions of the types of elder abuse and the presenting signs and symptoms.

TABLE 1. Types and Presentations of Elder Abuse

Type of Abuse	Presentations (includes, but are not limited to the following)
Physical abuse—the infliction of physical pain or bodily harm.	<ul style="list-style-type: none"> • Fractures; • Welts; • Bite marks; • Burns (unusual location, type, or shape similar to an object such as an iron or cigarette burn); and • Bruises (presence of old and new, shape similar to an object like a belt or fingers, bilateral on upper arms from holding or shaking, clustered on trunk from repeated shaking).
Sexual abuse—any form of sexual contact or exposure without consent or when the victim is incapable of giving consent (e.g., rape, fondling, forcing victim to watch pornography, or participate in unwanted sexual acts).	<ul style="list-style-type: none"> • Difficulty in walking or sitting; • Pain, itching, bruising, or bleeding in genital area; and • Unexplained venereal disease or genital infections.
Financial exploitation—illegal or improper exploitation of funds or other assets (e.g., stealing money or property, committing fraud through undue influence).	<ul style="list-style-type: none"> • Inaccurate, confused, or no knowledge of finances; • Unexplained or sudden inability or unwillingness to pay bills, purchase food or personal care items; • Unprecedented transfer of assets from an older person to other(s); and • Extraordinary interest by family member in older person's assets
Neglect—the refusal or failure to fulfill caregiving obligations, such as abandonment or isolation; denial of food, shelter, clothing, medical assistance or personal needs; or the withholding of necessary medication or assistive devices (e.g., hearing aids, glasses, false teeth).	<ul style="list-style-type: none"> • Dehydration; • Malnutrition; • Hyper/hypothermia; • Excessive dirt or odor; • Inadequate or inappropriate clothing; • Absence of eyeglasses, hearing aids, dentures or prostheses; • Unexpected or unexplained deterioration of health; • Decubitus ulcers; and • Signs of excess druging, lack of medication or other misuse (e.g., decreased alertness, responsiveness and orientation)

Why do spouses and other family members hurt older women? The stress of caregiving, the dependency of the victim, the psychopathology of the abuser, or learned behavior have all been proposed as responses to this query (Wolf 2000). Early interventions, such as adult protective services (APS), were created based on the belief that caregiver stress was the primary cause of elder abuse. The services were designed to relieve stress and to improve relationships between the elder and family members or caregivers. But, according to Wolf (2000), while stress may be a contributing factor, research does not support that stress is the primary cause of elder abuse. Rather, family violence in later life often involves an abuser using a regular pattern of coercive acts to control, dominate and/or punish the victim. These dynamics are similar to the experiences of younger battered women (Pillemer & Finkelhor 1988; Podnieks 1991; Wolf 1998).

When abusers believe they are entitled to "run the show," they will use any means necessary to meet their needs. An adult son may order his mother to do the laundry, cook his meals and turn over her Social Security check. If she doesn't, he may threaten her or hit her. An elderly man may have been battering his wife for 50 or 60 years to "Keep her in line." Abusers feel their actions are justified and that they have a right to control their victim, often because of stereotypical views about women or older people. Perpetrators often believe they deserve unquestioned obedience from the victim (Schechter 1987).

Understanding that domestic abuse in later life is most likely an issue of power and control is critical for health care providers. Since professionals may offer vastly different remedies depending on how the problem is perceived and defined. Unfortunately, too often well-meaning professionals assume that elder abuse is due to caregiver stress and make several crucial errors that further isolate and endanger the victim. Some health care providers may believe the abuse is caused because the person is difficult to care for. They may suggest that the victim try harder to do more for herself (whether this is possible or not), actions which blame the victim for the abuse and supports the abuser's contention that if the victim tried harder, he would not have to hit her.

Health care providers who see the victim as frail, old and dependent on the abuser (even if this is not true), may make decisions for the victim rather than use an empowerment strategy to assist the victim in helping herself. Dangerous practices can include: believing the abusers account that the victim is not competent or demented without doing an assessment; telling the victim what to do; or medicating victim rather than identifying the abuse.

When abuse is viewed as caregiver stress and only social service agencies are contacted, there may be failure to understand that domestic violence at any stage of life can be a criminal act. Some health care providers do not consider discussing legal remedies with older patients, assuming this to be a private family matter. However, many older women do take advantage of restraining/protective orders and other legal remedies when these options are made available to them. To provide safety and support to elderly victims, service models and legal remedies long established for younger victims of domestic abuse should be employed (Pillemer & Finkelhor 1989; Podnieks 1991; Vinton 1991).

IDENTIFICATION THROUGH UNIVERSAL SCREENING

In addition to clinical presentations previously identified, there are a number of behavioral indicators that should alert the health provider to the possibility of abuse. Some of the common behaviors exhibited by victims as well as by abusers can be found in Table 2. While it is important to recognize physical and behavioral "red flags" for domestic abuse in later life, abused woman may present with few of these symptoms. To increase the likelihood of identification, health care providers should adopt universal screening for every female patient and every person who is over age 60 and/or has a disability. When possible, questions should be asked in private, and not in the presence of an accompanying

TABLE 2. Behavioral Indicators

Patient	Abuser
<ul style="list-style-type: none"> • Have repeated "accidents" • Frequent vague or somatic complaints • Delayed presentations • Exhibits anxiety, depression, suicidal ideation • Express a sense of isolation--no access to money, friends, family, job, transportation, church, etc. • Refer to a family member's "anger" or "temper" or consistently defers to caregiver • Alcohol or drug abuse • Unable to follow through with medical care due to abuser's control or missed appointments • Present as a "difficult" patient 	<ul style="list-style-type: none"> • Verbally abusive or overly attentive or charming to the patient or health care staff. • Attempts to convince health care workers that the patient is incompetent or insane. • Controls most of patient's daily activities. • Overly protective or controlling of a family member (e.g., refuses to leave the room during exam or treatment)

family member. Patients should be advised that a positive response might prompt mandatory reporting to law enforcement and/or social services. (At the time of publication, all but six states, Colorado, New Jersey, New York, North Dakota, South Dakota, Wisconsin, have mandatory elder abuse reporting laws. State Adult Protective Services agencies can provide information about requirements for reporting elder abuse and/or domestic violence.) The patient should have an opportunity to talk freely and confidentially without fear of retaliation. If necessary, a reliable interpreter who is not a family member, should be available for non-English speaking or hearing impaired patients.

Screening should include a review of medical indicators and questions about family abuse. Indirect questions about the patient's life should be asked first and lead up to direct questions about specific acts. Evidence shows that victims of family violence generally respond positively to sensitive questioning from concerned professionals (Warsaw and Ganley 1998). Providers should identify any injuries and ask about how they occurred. Suggested questions include the following:

- Do you live alone?
- Who does your cooking?
- Who controls your finances?
- How often do you go out with friends?
- Are you afraid of anyone?
- Does anyone slap you? Pull your hair? Touch you in a rough way? Hit you?
- Does anyone threaten to do any of these things?
- Does anyone force you to do sexual acts you do not want to do?

Providers should identify any injuries and ask about how they occurred. Explanations of injuries that are inconsistent with findings or multiple injuries in various stages of healing should be discussed.

An older person may deny that abuse is occurring or refuse to talk about the possibility. There are a variety of reasons for nondisclosure. Language and cultural barriers may prevent the patient from confiding in her health care provider. Immigrant women may fear deportation. Lesbians may fear repercussions from friends, family members or the community if they have not disclosed their relationship.

The victim may believe she cannot escape the abuse and will be in greater danger if she reveals what is happening to her. Her past attempts to get help may have been futile and/or resulted in an escalation of the violence. Victims stay out of fear of being alone, real or perceived fi-

nancial dependency, health concerns, generational ties, or spiritual and cultural values. Many elderly victims fear retaliation and, in fact, research reveals that victims are often at greatest risk of being seriously harmed or killed when they seek help or attempt to leave the abusive relationship (Bachman & Saltzman 1995). Nevertheless, it is important to remember that screening—in and of itself—is a powerful intervention. It is helpful to leave open the possibility of future discussions. Often victims remember kind, supportive words of encouragement and referrals, even if they do not take action immediately.

COMPETENCY

Providers who are concerned that they are working with a patient who is not competent to make decisions about safety should follow their institution's medical protocol to determine competency. If a patient is assessed and determined to be incompetent, contact the county Adult Protective Services (APS) agency for consultation on the remedies (including legal options) and services available.

Competency should be tested only if there is evidence that the person has cognitive limitations. Keep in mind that many of the symptoms of dementia, depression and delirium such as poor judgment, confusion, lethargy, inability to communicate clearly, are also common and normal responses to victimization. The mental condition of many patients improves significantly within a few days when they feel safe and have had food, proper doses of medication, and sleep. Discomfort with a victim's choices is not sufficient reason to declare someone incompetent.

HEALTH CARE PROVIDER RESPONSE

Busy health care providers often feel they do not have time to adequately respond to the needs of victims of family violence. However, if simple protocols are established, physicians can easily incorporate screening into the health care visit and direct the patient to other staff members if abuse is disclosed. For example, other professionals, such as a domestic violence advocate or social worker, can be contacted to work directly with victims to ensure safety and offer ongoing support.

However, health care providers have an important role, whether they see a patient only once or have an ongoing relationship with her. Deciding what to do and implementing a plan of action can be a long, com-

plex process for many older women. Health care providers can offer supportive messages, document and photograph, ensure confidentiality, plan for safety, provide referrals, and honor her decisions.

OFFER SUPPORTIVE MESSAGES

Batterers often use a variety of tactics intended to make victims feel unsure of themselves. For example, some batterers may hide things, lie, or use medications inappropriately so that victims will appear confused. Often abusers tell victims of abuse repeatedly that they are to blame for the abuse. Health care providers can provide support and assurance to victims by listening empathetically to their stories and offering supportive statements such as "You are not responsible for the violence and abuse. The abuser's actions are wrong and not your fault." or "I understand how hard this must be for you to talk about. I believe you."

Many victims feel they are the only ones experiencing abuse. Education about the frequency of domestic violence and elder abuse may be especially helpful. Let the victim know that abuse rarely ends on its own; it may continue or escalate without some type of outside intervention. Assure the patient that their reactions are common for victims of abuse and praise their personal courage and strength. Validate and support the choices the victim makes to stay safe and alive.

People who live with domestic abuse often want the abuse to end but do not necessarily want to end the relationship. Expressing concerns about the patient's health and the extent of her injuries and/or emotional trauma may be helpful. Information from professionals that confirms a patient's fear, reassures her that the abuse is not her fault, and reinforces that the abuse may escalate can help the patient more realistically explore options.

DOCUMENT AND PHOTOGRAPH INJURIES

Documentation is critical for victims of family abuse who may later go to court. After obtaining consent, document injuries by taking photographs or using a body map. The medical record should include verbatim accounts from the patient about who caused the injury, how the injury occurred and note that the injuries are consistent with the patient's explanation of the cause. Write complete notes about what was said, observed and done. Include direct quotes of what the patient said

happened and/or statements made by the suspected abuser. Avoid language such as "alleges" which suggests the information given is questionable. Avoid judgment statements about the victim such as "she was hysterical and overreacting." Finally, document what interventions were offered (e.g., police, social services, safety planning) and the outcomes (e.g., accepted brochures, consulted with a social worker). If abuse is reported to Adult Protective Services (APS) or law enforcement, document the date and time of the call.

ENSURE CONFIDENTIALITY

Health care providers are responsible for ensuring confidentiality so that they do not put patients at risk. Family abuse screening should be done with only the patient and health care provider present, unless an advocate or interpreter is requested. The patient's chart should be placed where the abuser and other unauthorized persons cannot have access to it. Case discussions should be held in private. Other patients and health care providers uninformed with the case should not be included or able to overhear the discussion. Documentation should go in the patient's chart, not on other family member records. Phone calls or mail should not be directed to the patient's home to discuss abuse without permission from the patient. When filing sensitive information, consider who may have access to files and computer records, particularly if a victim's family member or friend works in the medical setting.

PLAN FOR SAFETY

Safety planning is an ongoing process. Ideally, the health care provider and victim discuss safety options for the victim's particular set of circumstances. Safety planning tools often are available from the local or statewide domestic abuse programs and from a variety of national health care organizations. Questions may include the following:

- "What have you done to keep safe in the past?"
- "If the violence escalates, do you have a place to go?"
- "Can you call the police or a neighbor, etc.?"
- "If you need to leave the abuser, where can you go?"
- "What do you need to bring?"

- "If you decide to return, how can you plan for your safety and get support?"

Sometimes safety planning requires creative thinking. For example, health care providers may write the crisis line telephone number on medical papers such as prescriptions. The telephone number can be disguised as administrative codes so that the victim will be able to keep the number handy without raising abuser suspicion. Another suggestion is to use a personal emergency system for safety. In some communities, a personal emergency system such as a lifeline (necklace with a button to contact emergency medical personnel) has been used for both medical emergencies and domestic abuse cases. The lifeline staff calls the subscriber's home when the button is depressed. If the elderly individual does not return the call or if the emergency personnel are prevented from talking directly with the woman, the police are notified to investigate.

REFER TO AVAILABLE SERVICES

The services offered to a victim of abuse will depend on the wishes and needs of the patient. Many victims of abuse benefit from free domestic abuse services including emergency shelter (if they choose to leave the abuser), support groups, peer counseling, and crisis lines. A support group may be extremely helpful; especially a group with people who are the same ages as the victim. For example, older abused women's support groups exist in many communities (Seaver 1996).

Some victims will use the legal system to have the abuser arrested, secure a restraining order or divorce, or establish a financial guardian (conservatorship). Other victims may benefit from services offered by aging network such as transportation, peer support, supportive home care, home delivered meals, or financial counseling.

Often Adult Protective Services (APS) is involved in elder abuse cases. APS or their equivalents are social service agencies mandated to investigate cases of elder abuse or abuse of a vulnerable adult. Calls come to a central agency, which assigns a trained worker to investigate the allegations of abuse and/or neglect. State statutes vary on how immediately a worker must respond. In some states, alleged victims may refuse the investigation. In other states, an investigation is completed but competent patients have the right to reject services.

HONOR HER DECISIONS

The decision to end a relationship with a new spouse/partner, a long-term spouse/partner, or an adult child or grandchild can be painful. Few victims leave the first time they reach out for help. While it may be frustrating to the healthcare provider, some victims of family violence stay with abusive family members. Others may leave, only to return home after a few days or months. Change of this magnitude often comes slowly and over time, especially for the elderly, who by virtue of aging may already be experiencing many losses, such as health and social support (Seaver 1996). Communicating support for the patient and the patient's health, no matter what decision is made, plays an important part in the victim finding strength to make difficult choices.

DANGEROUS INTERVENTIONS

The following actions may place an abused older person at increased risk. Health care professionals should exercise caution before doing any of the following:

- *Prescribing antidepressants or sedatives without a thorough abuse assessment.* Older people and victims of family violence frequently are offered medications rather than support and assistance to live free from violence. Prescribed medications may lessen a person's ability to respond effectively in a crisis. Medications can also send a message to the patient that "you are the problem" or mimic messages from the batterer that "you are crazy."
- *Recommending couples or family counseling without treatment for the batterer.* Couples and family counseling is contraindicated unless the abuser has successfully completed a batterer's treatment program, fully accepts responsibility for the abuse, and has stopped the violence (Golden & Frank 1994; Schechter 1987).
- *Blaming the victim.* Professionals often wonder why victims stay with their abuser. They may offer remedies that suggest that if the patient would try a little harder, the abuse would not occur. Without an understanding of the dynamics of family abuse, health care providers may be frustrated by patients who use the health care system regularly without leaving the abusive relationship (Worcesster 1992). Rather than focus on the patient's choices, it is important

- to remember that abusers are solely responsible for their behavior and must be held accountable for their actions.
- Colluding with the batterer.* It is important for health providers to differentiate between temporary caregiver stress and domestic violence. If it is assumed the abuse is caused by temporary loss of control rather than imposition of control over another person, messages to the abuser may inadvertently justify his behavior. Expressing concerns about how difficult it is to be providing care to an elderly may justify or reinforce the abuser's belief that it is acceptable to use whatever means necessary to get their way. Blaming alcohol/drug use, stress, anger, or mental illness for the abuse is ill-advised. Abusers must be held accountable for their actions before they will change their behavior (WCADV 1999).
- Minimizing the potential danger to the victim or health provider when help is offered.* Arrange for appropriate security for the victim, yourself and staff when working with a potentially lethal batterer (e.g., he has made homicidal/suicidal threats or plans, owns weapons). When the victim is in danger, the provider and staff may be as well.

HEALTH CARE SYSTEM RESPONSE

Health care providers have an obvious stake in joining the community's efforts to end family violence. To eliminate domestic violence in later life, systemic change is crucial. Health care providers can join other professionals to create services and challenge societal beliefs and norms that perpetuate a culture where family abuse continues to grow. Several ways health care providers can participate in systemic change are listed below.

- Work with domestic violence specialists to establish an older women's support group at local hospitals or clinics.
- Help educate other health care professionals and the public (including the media) on elder abuse and domestic violence.
- Join a multidisciplinary team or a coordinated community response effort.
- Become a board member or fundraiser for a local domestic abuse program, aging agency or statewide coalition against domestic violence.

- Participate in local or statewide efforts to improve options for battered women and elder abuse victims such as public awareness campaigns or lobbying.
- Join the efforts of health care organizations working to eliminate family violence.

CONCLUSION

Older women suffer from abuse and neglect primarily at the hands of family members. Health care providers can affect the quality of life and improve the health of older female patients through recognizing domestic abuse. Providers can accomplish this through universal screening of all patients, documentation, and referrals that include safety planning and reporting abuse to authorities. Joining systemic efforts to prevent family violence also is consistent with the provision of high quality health care.

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