Assessing for Abuse in Later Life

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Elder abuse, which includes abuse by a current or former intimate partner in later life, is a growing and often hidden problem. In the year 2000, approximately 35 million Americans were over 65 years of age. According to projections, the number of Americans who are 65 years of age or older will increase to 40 million by the year 2010 and 54 million by the year 2020 (Administration on Aging, 2002). With increasing awareness about abuse in later life and an aging population, the number of reported elder abuse cases has also increased. Although 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 by 150 percent (National Center on Elder Abuse, 1998).

Health care providers are in a unique position to identify and address elder domestic violence and abuse. Older women who have experienced abuse often seek medical treatment for physical injuries, psychosomatic complaints, depression, anxiety, and symptoms of post-traumatic stress disorder (PTSD). They may contact health care professionals due to their current abusive situation or because of the continuing impact of being survivors of child abuse, incest, rape, and domestic violence earlier in their lives. Reported and corroborated elder mistreatment and self-neglect are associated with shorter survival after adjusting for other factors

that are linked with increased mortality in older adults (Lachs et al, 1998). Early identification and intervention can improve the quality of life for older victims. Addressing the root of a patient's problem rather than solely treating the presenting symptoms can lead to more efficient and effective health care services, improved patient outcomes, and reductions in health care costs.

The following stories are from older abused women who talked about their experiences with the health care system at a support group in Massachusetts. These stories illustrate the importance of identifying elder abuse as a health concern and the pivotal role that a health care provider can have in assessment and intervention for abuse in later life.

- "After my aneurysm, my doctor knew what had been going on at home and he would not let me go back. He told me I had to go to a rehab or to my sisters for two weeks first. That was the best thing he could have done because after that I knew I could never go back home. I left my husband six times before but that was the last time. I never did go back to that house." (Terry, age 69)

- "My doctors were wonderful even though I was in and out of that relationship for 33 years. I had one medical problem after the other, migraines, colitis, anxiety, fibromyalgia, ulcers. You name it, I had it. The doctor and the nurse said it was due to the stress I was living with. They understood. They took the time to really listen to me. They didn't judge me." (Betty, age 58)

- "I was always in so much pain. The doctor ran so many tests but could never find anything wrong. That's when she talked with me about what stress can do to you. All my pain left when I moved out and I can eat again too!" (Julie, age 79)

ELDER ABUSE AND DOMESTIC ABUSE IN LATER LIFE

Elder abuse is generally defined as physical, sexual and emotional abuse, financial exploitation, neglect and self-neglect, and abandonment of an older person (NCEA, 2004). State statutes differ on the specific definition of elder abuse. The National Elder Abuse Incidence

Study found that family members were the abusers in 90 percent of cases and that older women are abused at a higher rate than males (NCEA, 1998). Elder abuse generally occurs in the person's domicile, whether it is a private dwelling in the community or a facility such as a nursing home.

Domestic abuse in later life is a subset of elder abuse. Like other forms of elder abuse, older women and men are victims of abuse by someone they know or love. Spouses, partners, adult children, other family members or caregivers – someone with an ongoing, trusted relationship with the victim – can all be abusers. Spousal or partnerships may be long-term, for example, marriages that have lasted 40 years or more. Another scenario is a new relationship, often following the death or divorce from a previous partner. The abuse may occur throughout the relationship or be a relatively new occurrence.

Why do spouses and other family members hurt older women? Current research indicates that the most common reason for abuse in later life is power and control dynamics that are similar to the experiences of younger battered women (Pillemer & Finkelhor, 1988; Podnieks, 1992; Harris, 1996; Wolf, 1998). In these cases, the abuser feels a sense of entitlement to use various forms of abuse to gain and maintain power and control over the victim. These abusers will use a pattern of coercive tactics and whatever method necessary, including isolation, intimidation and threats, withholding food, medication and sleep, and physical and sexual abuse to get their way (Schechter, 1987). In some cases of domestic elder abuse, the perpetrator has a medical condition, such as Alzheimer's disease or a related dementia that manifests itself as aggressive and challenging behaviors.

Despite the popular image that elder abuse is primarily caused by stressed caregivers

and dependent elders, "evidence is accumulating that neither caregiver stress levels nor victims' levels of dependence may be core factors leading to elder abuse (Wolf, 2000)." While some cases of abuse in later life may be caused by caregiver stress, in many other cases abusers excuse their behavior by claiming they were overwhelmed or by labeling the victim as difficult. Understanding that domestic abuse in later life is most likely an issue of power and control is critical for health care providers. Professionals will offer different options depending on how the problem is perceived and defined. Well-meaning professionals who assume that elder abuse is due to caregiver stress may make several crucial errors that further isolate and endanger the victim. Practices that may endanger a patient when abuse in later life is suspected or identified include relying on the abuser's account that the victim is demented or not competent. Instructing the victim to leave, telling the victim to kick the abuser out of the home, and medicating the victim rather than addressing the abuse can also endanger an older patient experiencing abuse. When a victim of domestic violence has had control of her life taken away by the abuser, she needs to have the power of making choices restored to her, not further removed by well-intended professionals (Brandl & Raymond, 1997). Finally, when abuse is viewed as caregiver stress, only social service agencies are contacted. However, domestic violence at any stage of life may require a criminal justice response. To provide safety and support to elderly victims, service models and legal remedies established for younger victims of domestic abuse may be most effective (Dunlop, 2000; Pillemer & Finkelhor, 1989; Podnieks, 1992; Vinton, 1991).

ASSESSING FOR ABUSE IN LATER LIFE

Too often, health care professionals categorize abuse by an intimate partner as a younger

woman's issue. Health care providers may treat older women differently and therefore miss evidence of abuse. Screening questions may not be asked of women over 60. Bruises may be explained away as signs of aging. Health care providers may only consider domestic abuse by an intimate partner but fail to recognize an abuser who is an adult child, family member, or caregiver. Sometimes suspicious or questionable behavior by a potential abuser is overlooked.

To increase identification of elder and domestic abuse, health care providers should adopt universal screening for all females, all patients over 60 years of age, and anyone who has a disability. When possible, questions should be asked in private so that answers may be given freely without fear of reprisal. Patients should be advised that disclosure of abuse might prompt mandatory reporting to law enforcement and/or adult protective services. A reliable interpreter who is not related to the patient should be available for non-English speaking patients or patients who are deaf or hard of hearing. Examples of screening questions include:

- How often do you go out with friends?
- How are decisions made about how you spend money?
- 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 have sexual activities?

INDICATORS OF ABUSE IN LATER LIFE

Elder abuse may also be identified during the physical exam. Table 1 lists five major types of abuse and indicators that are associated with elder abuse and domestic violence in later

life. Different forms of abuse are often used in combination. For example, emotional abuse often accompanies financial exploitation. When one form is identified or suspected, it is important to ask questions about all other types of abuse including sexual abuse.

Table 1. Types of Abuse and Indicators in Later Life (NCEA, 2004)

Type of Abuse	Signs and indicators include but are not limited to:
Physical abuse	• Bruises, black eyes, welts, lacerations, and rope marks • Bone fractures, broken bones, and skull fractures • Untreated injuries in various stages of healing • Sprains, dislocations, and internal injuries/bleeding • Broken assistive devices like glasses, dentures, canes • Physical signs of being restrained • An elder's report of being physically abused
Sexual abuse	• Pain, itching, or bruises around the breasts or genital area • Unexplained venereal disease or genital infections • Unexplained vaginal or anal bleeding • Torn, stained or bloody underclothing • An elder's report of being sexually harassed, assaulted, or raped
Emotional abuse	• Being emotionally upset or agitated • Being extremely withdrawn and uncommunicative or non-responsive • An elder's report of being verbally or emotionally mistreated
Neglect	• Dehydration, malnutrition, untreated bedsores, and poor personal hygiene • Unattended or untreated health problems • Inadequate or inappropriate clothing • Unexpected or unexplained weight loss or deterioration of health • Signs of excess drugging or under-medication • Unsanitary and unsafe living conditions (e.g., dirt, fleas, lice, soiled bedding, dried fecal matter, urine smell, lack of heat/plumbing) • An elder's report of being mistreated/neglected
Financial exploitation	• Lifestyle not consistent with income/assets • Unexplained or sudden inability to pay bills, purchase food or personal care items • Fear or anxiety when discussing finances • Unprecedented or unusual transfer of assets from victim to others • Extraordinary/unusual interest by family members in victim's assets • Abrupt changes in a will or other financial documents • Unexplained disappearance of funds or valued possession • Discovery of an elder's signature being forged for financial transactions or for the titles of his/her possessions • The provision of unnecessary services • An elder's report of financial exploitation

Victims and abusers may display behavioral indicators that should raise health care providers' suspicion for elder and domestic abuse. Table 2 provides examples of behaviors that may be indicative of abuse in later life. Providers should trust their instincts. If a provider is suspicious of abuse, they should ask the patient additional questions that hone in on their concerns. Providers should also keep in mind that abusers may lose their freedom, reputation, financial resources, housing, and their access to the victim if they are caught.

Table 2. Behavioral Indicators (Brandl, 2002)

A Potential Victim May	A Potential Abuser May
Have injuries that do not match explanation by patient or others	Minimize or deny the abuse has occurred
Have repeated "accidental injuries"	Blame the victim for being clumsy or difficult
Appear isolated	Be overly charming and helpful to the professional OR abusive to the professional (e.g., "I'll call your supervisor" or "I'll sue you.")
Say or hints at being afraid	Act loving and compassionate to victim in professional's presence
Consider or attempt suicide	Agree to a plan but never follow through
Have history of alcohol or drug abuse (including prescription drugs)	Want to be present for all interviews
Present as a "difficult" client	Answer for victim
Have vague, chronic, non-specific complaints	Say victim is incompetent, unhealthy or crazy
Be unable to follow through on treatment plan or medical care	Use the system to their advantage or against the victim by threatening "their rights"
Miss appointments	Threaten suicide
Delay seeking medical help	Prohibit victim from purchasing needed items
Exhibit depression (mild or severe)	Turn family members against the victim
Exhibit evidence of effects of stress and trauma such as chronic pain and other illnesses	Talk about how good the victim has it or how ungrateful the victim is
Have a sudden change in behavior	Threaten to hurt the family pet

WHAT IF THE VICTIM DENIES BEING HARMED?

An older person may deny that abuse is occurring or refuse to talk about it. The victim may believe she cannot escape the abuse and will be in greater danger if she reveals what is happening to her. Victims often stay in relationships out of fear of being alone, real or perceived financial dependency, health concerns, generational ties, and 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). Even so, providers should remember that screening and asking about abuse are powerful interventions on their own that should be engaged. It is important to leave open the possibility of future discussions. Victims often remember kind, supportive words of encouragement and referrals, even if they do not take action immediately. If there are questions about whether the victim is competent or suffering from dementia, providers should consult with experts in mental health and gerontology. A person with dementia may be a victim of abuse. Even if the older person is confused about other events, providers should explore the possibility of current abuse or memories of past trauma that are now coming to the surface.

RESPONDING TO ABUSE IN LATER LIFE

While healthcare providers may feel that they do not have the time to adequately respond to abuse in later life, the same brief interventions that are recommended for younger patients who disclose domestic violence can help patients who disclose abuse in later life. Interventions for abuse in later life include offering supportive messages, documenting a patient's disclosure of abuse or the provider's concerns if there are indicators of abuse and the patient does not

disclose, and helping a patient plan for safety by providing information, discussing options, and providing referrals. Age-appropriate resources and referrals should be provided when available. Seaver (1996) noted that support groups can be extremely helpful, especially a group with people who are of the same generation as the victim.

MANDATORY REPORTING FOR ELDER ABUSE

Forty-four states require that health care providers report suspected or identified cases of elder abuse. Six states that do not mandate reporting but operate voluntary systems are Colorado, New Jersey, New York, North Dakota, South Dakota, and Wisconsin. Reports go to APS staff who investigate cases of elder abuse or abuse of vulnerable adults. Calls usually go to a central agency and are then assigned to a worker. APS staff investigates allegations and offer services, which competent clients can accept or reject. Providers should be aware that some states also mandate reporting domestic violence or specific crimes to law enforcement.

A MORE COMPREHENSIVE APPROACH

Elder abuse is an emerging epidemic. As service providers continue to broaden their understanding of the continuum of abuse over the lifespan, there is an urgent need for more age-appropriate resources for victims who experience abuse in later life. More research is needed to develop and evaluate assessment tools and intervention strategies for clinical and public health settings. Training on assessment and intervention for family violence should include elder abuse. Health care professionals are in a unique position to assess for abuse in later life, offer hope and support, and make referrals for patients who disclose abuse. For more information,

contact the National Clearinghouse on Abuse in Later Life (NCALL), a project to the Wisconsin Coalition Against Domestic Violence at our website: www.ncall.us, by e-mail at ncall@wcadv.org, or phone at (608) 255-0539. NCALL offers technical assistance, consultation, training, and educational resources.

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