DOMESTIC ABUSE AND OLDER ADULTS

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INTRODUCTION

Domestic abuse (DA) is a societal issue that has received a significant amount of academic attention. However, DA among older adults has been described as virtually unrecognised and resources are nonexistent (Phillips, 2000). In more recent years this deficit in both research and resources for older adults has been acknowledged worldwide (Band-Winterstein & Eiskovits, 2009; Lundy & Grossman, 2009; McGarry & Simpson, 2010; Straka & Montminy, 2006). Despite the research on this topic now gaining momentum, more recent articles still describe older women as invisible victims of DA within both academic (e.g. Simmons & Baxter, 2010) and public (e.g. Howard, 2016) contexts. Therefore, it is important to examine the impact of DA on older adults. In line with existing literature the definition of an 'older adult' includes anyone aged 55 and older.

Domestic abuse is defined as threatening behaviour, violence or abuse that can be psychological, physical, sexual, financial, or emotional in nature. This usually occurs between adults who are or have been intimate partners or family members, regardless of age, race, gender, or sexuality (Sanderson, 2008). Intimate partner violence is commonly associated with DA. In the UK it is estimated that one emergency call related to DA is reported to the police every 30 seconds and current or former male partners kill an average of two women a week (Women's Aid, 2015). However, many incidents still go unreported and therefore the true prevalence of this crime is unknown (Hall & Smith, 2011). For older adults the extent of DA is even more difficult to establish as it is often confused with family violence or elder abuse (McGarry, 2008) and national statistics frequently do not collect information on those over the age of 59. DA is multifaceted and if those who need help are not given the correct support it can leave them vulnerable to dangerous environments.

BEHAVIOURAL CHARACTERISTICS OF DOMESTIC ABUSE IN OLDER ADULTS

Although older victims report similar patterns of abuse to younger victims, changes in behavioural forms and severity of the abuse have been identified among older samples. Many older

women report a decline in the physical and sexual aspects of abuse as their male partners age (Lundy & Grossman, 2009; Stockl, Watts & Penhale, 2012; Zink, Fisher, Regan & Pabst, 2005; Zink, Jacobson, Regan, Fisher & Pabst, 2006). In a sample of 3,636 participants, Zink et al. (2005) found women over 55 years reported physical and sexual abuse less frequently than younger women. Furthermore, in a national survey of DA in Germany, Stockl et al. (2012) observed a decline in physical and sexual violence as the couple aged, with only 5% of those in the 66-86 age group reporting such behaviours compared to 12% of 50-65 year olds. However, the reduction in physical aspects of abuse appears to correlate with an escalation of psychological abuse and non-violent controlling behaviours. For example, Zink et al. (2006) found psychological abuse continued into old age with some of the women they interviewed describing an escalation in this form of abuse. Furthermore, although all forms of intimate partner violence have been linked to a decline in women's health symptoms, Stockl and Penhale (2014) found controlling behaviour was consistently associated with most health symptoms.

The impact of psychological and controlling behaviours should not be underestimated. Psychological and emotional abuse can take many forms, such as partners conducting extramarital affairs, controlling finances, and isolation from friends and family, to name a few; each can have a detrimental effect on the victim's health and well-being. Other forms of controlling behaviours identified among older women include perpetrators exerting control over their partner's cancer treatment. Sawin and Parker (2011) found that women they interviewed believed their partners felt threatened by the increased attention received as a result of a cancer diagnosis and made deliberate efforts to shift attention back to them. Further controlling behaviours included the abusive partner insisting on the use of wigs during treatment, despite their partner's discomfort with the request.

IMPACT ON HEALTH AND WELL-BEING

There are a number of physical and mental health implications for older adults living with DA. Results of a study by Lazebatt, Devaney and Gildea (2013) indicated that three quarters of the women they interviewed defined their mental and physical health as "very poor". Living with long-

term physical and psychological abuse has extreme negative effects on wellbeing and increases the likelihood of depression, anxiety (Lazenbatt et al., 2013; McGarry, Simpson & Hincliff-Simth, 2011) and the risk of suicide (McGarry & Simpson, 2011). A negative impact on cognitive functioning has also been linked to DA. Many victims report memory lapses and difficulties with concentration (Scheffer-Lindgren & Renck, 2008). Such responses to trauma can easily be overlooked and explained as aging and older life health issues.

In addition to mental health, long-term abuse has been linked to a number of physical health problems. Stockl and Penhale (2014) found, in a sample of 10,264 women in Germany, that all forms of DA were associated with a number of health problems including gastrointestinal, and psychosomatic symptoms, as well as pelvic problems. Moreover, in a study involving 842 women age 60 years and older, bone and joint problems, digestive problems, chronic pain, and high blood pressure were reported as a result of the psychological abuse they had suffered (Fisher & Regan, 2006). Additionally, connections between chronic pain and DA have been acknowledged among older women. Chronic pain can occur as a result of repeated physical violence or occur as a trauma response of long-term abuse (Coker, Bethea, Smith, Fadden & Brandt, 2002). Back pain has been identified as a common source of chronic pain for women living with DA (Balousek, Plane & Fleming, 2007; Wuest, Merritt-Gray, Ford-Gilboe, Lent, Varcoe & Campbell, 2008). The pain can be linked to feelings of shame, self-blame, and loss of control and can act as a reminder of the abuse, which can be detrimental to on-going recovery. Wuest et al. (2008) describe the emotional turmoil of living with DA as playing a part in the maintenance of the back pain while the chronic pain contributes to the mental health symptoms. Therefore, identifying the impact of DA both physically and psychologically is important when working with older adults to ensure their care needs are met.

Substance misuse is a further problem often associated with victims of abuse. Heavy alcohol use, smoking, and the use of prescription and non-prescription drugs are coping methods that older women victims have described using to block out trauma associated with DA (Lazenbatt, Devaney

& Gildea, 2010; 2013). Furthermore, Wuest et al. (2008) found that experiencing high pain was associated with the use of prescribed medication beyond the recommended dosage. Many of the strategies women employ to cope with abusive relationships are behaviours that put them at further risk of declining health and early mortality.

BARRIERS TO SEEKING SUPPORT

There are a number of reasons why people decide to keep the abuse from their families, friends, and authorities. Many victims feel ashamed or embarrassed or may blame themselves (Scheffer-Lindgren & Renck, 2008); others may believe it will soon end or that it was a one-off incident. Many victims want to protect their partner and maintain the relationship, while some women do not report the abuse due to fear of the repercussions from the perpetrator (Fugate, Landis, Riordan, Naureckas & Engal, 2005). Older adults often have additional barriers. Staying with the abuser and keeping the family together is considered as a way of protecting the family unit (Tetterson & Farnsworth, 2011). Powerlessness and fear of homelessness add to the difficulty of an older woman leaving an abusive relationship (Zink, Regan, Jacobson & Pabst, 2003). This can include fear of losing relationships with adult children, family, and friends (Lazenbatt et al., 2010). Often older women are more submissive to the family unit and have more years invested in their families than their younger counterparts (Zink et al., 2003; Band-Winterstein, 2012). Furthermore, older women have often had less opportunity for education or learning new skills, which can add to feelings of financial vulnerability due to traditional gender roles lending themselves to women being at home with the family while the man goes out to work (Band-Winterstein, 2012; Zink et al., 2003). The declining health of both the victim and the perpetrator can be an additional barrier to reporting DA (Zink et al., 2003) and many older women have special care needs or disabilities (Lundy & Grossman, 2009) that are not catered for in current service provision. Isolation from friends and family frequently has a strong influence on help-seeking behaviours. For an older adult this may be more problematic due to having additional care needs or less mobility due to declining health, and physical or cognitive incapacities.

Many women in abusive relationships blame themselves, which leads to acceptance of the abuse. For older women this can be particularly problematic as many older adults grew up in generations where socialisation to traditional gender values was prominent (Band-Winterstein, 2012; Straka & Montminy, 2006). This way of life is more engrained and normalised. As people age they become more accepting of their life and less likely to make changes (Seff, Beaulaurier & Dunlop, 2005). Zink et al. (2003) report that many of the older abused women they interviewed were surprised to find that their experiences were not typical of the general population. Part of this problem is the reluctance to discuss 'what happens behind closed doors'. McGarry and Simpson (2011) found the women they interviewed discussed the home as being a private place and it was not considered appropriate to disclose problems at home. The reluctance to talk about problems at home, combined with aging and subsequent care needs, leaves older adults vulnerable to the DA they are experiencing not being identified by the professional they come in to contact with.

For older women DA is not always recognised by professionals and it may be confused with some other form of abuse. Brandl (2002) and Straka and Montminy (2006) identify problems that can occur when DV is not adequately investigated. Caregiver stress theory is one example. This theory purports that abuse is minimised and explained as the caregiver becoming stressed and too heavy-handed with the victim. In such cases the caregiver is given support by intervening services and the victim is not, leaving them even more isolated and vulnerable. For older adults, particularly those with physical or cognitive disabilities, it is often the case that one partner is the primary carer for the other. This can be problematic when the abusive partner is considered the main carer. It is essential that all cases are fully investigated and reviewed sufficiently to ensure that the heavy-handedness of the caregiver is not symptomatic of DA.

ASKING THE RIGHT QUESTIONS AND GIVING THE RIGHT ANSWERS

It is important that professionals ask questions about DA and discuss health implications and support services. Brandl (2002) argues that many women are waiting for a sympathetic ear to help them become empowered to seek support but are rarely given those opportunities. Health care

professionals are often in a good position to assess and screen for abuse in elder relationships as well as providing their patients with knowledge of available resources (Mouton, 2003; Simmons & Baxter, 2010). Lazenbatt et al. (2013) found a number of older women suffer in silence due to the signs of abuse not being recognised by the professionals they are in contact with. The women they interviewed described using A&E departments multiple times with no one asking questions about DA or offering information about support that is available. Health professionals have reported lacking confidence or knowledge to screen for DA (Bonomi, Anderson, Reid, Carrell, Fisherman & Rivara, 2007; Selic, Pesjak & Kersnik, 2011). Furthermore, professionals describe feeling helpless when working with victims of DA as they often do not want to offend the woman by discussing the DA and thus do not refer on to specialist services (Rose, Trevillion, Woodall, Morgan, Feder & Howard, 2010) Feelings of helplessness and frustration in identifying and supporting older victims of DA has additionally been found among a range of practitioners such as social workers, specialist charities, and staff in forensic units (Penhale & Porrit, 2010). It is essential that provisions are available with adequately trained staff to recognize the signs of DA among older victims.

When exploring differences between IPV in older and younger adult relationships Yechezkel and Ayalon (2013) discovered that social workers were able to identify physical abuse within relationships more easily than psychological abuse. This is alarming due to psychological abuse being more dominant within older adult relationships. Furthermore, the social workers in the study were more likely to identify a younger victim's case as abuse than when the same case was presented with an older victim. Other research that has examined differences in younger and older victims of DA has focused on behavioural patterns of the abusers, help-seeking behaviours, and available resources; therefore more research is needed to explore how practitioners identify and classify abuse across different age groups.

CONCLUSIONS AND FUTURE RESEARCH

It is essential that there is appropriate service provision to adequately meet the needs of older victims of DA. Furthermore, it is important that service providers and professionals can recognise the signs of DA among older adults. Much of the existing literature indicates a shift in type of abuse suffered over time from mainly physical and sexual in nature, to predominantly psychological. Therefore, it is vital that practitioners are skilled in recognising the non-violent signs of DA and that they understand the multifaceted nature of this form of abuse.

The majority of research that has explored DA among older adults has largely focused on male perpetrators and female victims. Statistics suggest that 1 in 6 men are victims to DA and over the last 10 years research exploring DA within same-sex relationships has increased. Thus it would be useful to consider such factors in an older adult population.

It is imperative to consider service responses to older adults living with DA. While clinical and health care providers are in a unique position to recognise signs of DA, they are not always equipped to do so. Services *must* develop to meet the needs of older adults (Lazenbatt et al., 2010; 2013; McGarry & Simpson, 2010; 2011; Mouton, 2003) and it is essential that *all* practitioners who have access to older adults are working collectively to recognise and report concerns about domestic abuse. This must be addressed to ensure older women are supported when they are at their most vulnerable.

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