abstract

Violence against older women involves physical, emotional, sexual and financial abuse and denial of human rights, often in combination with one another. Abuse is gender- and age-based. The gender-neutral focus of the elder abuse field does not address the key issues of abuse of women in later life. Community-based women's advocacy and services in the past have failed to recognize and address the needs of older women. By developing an appreciation of issues of gender- and age-based violence, health professionals have increased opportunities to help older women find support and assistance.

Key words: *elder abuse, gender violence, women, aging, older women.*

Age, Gender and Violence: Abuse Against Older Women

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Introduction

According to most research studies, the majority of older victims of violence are women and the majority of perpetrators are male.[1-5] Older women's health status will often reflect consequences of living with recent or life-long physical, emotional or sexual violence.

There are many attitudes and perceptions in our society that inhibit the recognition of abuse and violence in later life as being a part of the continuum of violence against women. Abuse of a woman in her 50's or older is usually viewed as age-related and categorized as "elder abuse", a gender-neutral term. When age alone defines her abuse, the reality of a woman's life disappears from consideration.

The common assumption is that victims of "violence against women" are young women, often with babies or toddlers, living with abusive partners. But violence is also a fact of life for many older women. Their abuse may have started as a young wife or mother, may begin in a new relationship developed later in life, or may be perpetrated by adult children, even grandchildren. But older abused women are invisible. Our research in British Columbia documents women being abused from childhood into their senior ages.[6]

Table 1: Gender Violence throughout a Woman's Life

Phase	Type of Violence
Prenatal	Sex-selective abortions, battering during pregnancy, coerced pregnancy (rape during war)
Infancy	Female infanticide, emotional and physical abuse, differential access to food and medical care
Childhood	Genital mutilation; incest and sexual abuse; differential access to food, medical care, and education; child prostitution
Adolescence	Dating and courtship violence, economically coerced sex, sexual abuse in the workplace, rape, sexual harassment, forced prostitution
Reproductive	Abuse of women by intimate partners, marital rape, dowry abuse and murders, partner homicide, psychological abuse, sexual abuse in the workplace, sexual harassment, rape, abuse of women with disabilities
Old Age	Physical, sexual, psychological, and financial abuse by intimate partners, adult children and grandchildren, and homicide

Source: Adapted from Heise, 1994[10]

Table 2: Red Flags: Some Signs of Possible Abuse

Repeated accidental injuries
Injuries that do not match the account of what happened, including cuts, bruises, swelling, grip marks, burns, injury to scalp, evidence of hair pulling
Nervousness or fear when partner or family member present
Partner or other family member shows anger or irritability toward patient
Accompanying partner or family member answers questions for patient.
Reluctance of partner or family member to leave patient alone with physician
Vague chronic health complaints
Signs of depression or confusion
Frequent visits to emergency room
Doctor shopping
Limited social contact outside the home
Change in appearance, clothing or hygiene
Standard of living and care is not in keeping with income or assets

Women who enter their older years with a history or current experience of violence and abuse often suffer persistent health problems, including chronic pain, depression and disability. To what extent are health-related problems seen in older women and attributed to aging associated with a history of recurrent assault by a family member? According to the World Report on Violence and Health,[7] available evidence shows that victims of domestic and sexual violence have more health problems, significantly higher health care costs, and more frequent visits to emergency rooms, compared to groups with no history of abuse. As we learn more about the outcomes of abuse in later life, we recognize the serious consequences for older frail women with a lifelong history of abuse. Research reported in the *Journal of the American Medical Association* in 1998 indicates a three-fold increased risk of death for older adults living in the community with a reported history of abuse.[8]

Physicians and other health professionals who interact with older women are in a unique position to recognize indicators of abuse, and to provide information on community resources for abuse victims. Although a physician may see an older woman frequently, he or she may miss opportunities to recognize an underlying issue of abuse that may have precipitated the visits. By developing an appreciation of issues of gender violence and age, health professionals are more likely to identify the impact of current or past abuse on an older woman's physical, psychological and spiritual health and wellbeing. There is an opportunity to give information on help and resources.

Gender, Violence and Age

Gender structures interpersonal relations throughout the life cycle, and gender differences in aging reflect biological, economic and social differences. An epidemiological report from the Johns Hopkins University School of Public Health[9] suggests that research and advocacy activities demonstrate a growing consensus that abuse of women and girls is best understood within a gender framework, since this abuse stems in part from women's and girls' subordinate status in society. This violence shapes women's lives from birth through old age. It cuts across age, race, class, economic status and religion. Violence is a fact of life for many women of all ages, and no girl or woman is ever free of gender discrimination.

Table 1 has been modified from a resource that has been widely used since 1994[10] to summarize a global perspective on gender-based violence throughout a woman's lifecycle. It has been modified to reflect how the risks to older women—physical, sexual and psychological, financial abuse and homicide by intimate partners—are similar to those faced by younger women. In addition, older women may be abused by adult children, grandchildren and, for frail women, caretakers.

Violence Against Women or Elder Abuse: Does it Matter?

When abuse in later years is considered only within the context of "elder abuse", distinctions such as gender are commonly ignored. This supports a perception of older adults as sexless, and treats male and female victims of abuse in later life as indistinguishable. This perspective ignores the dynamics of family relationships by implicitly associating abuse of older women with "caregiver stress". However, it is likely that the majority of abused older women do not require the assistance of a caregiver.[4]

Violence against younger women was identified by the women's movement and was incorporated as a social problem and an aspect of larger issues of gender discrimination and inequality. Sadly, those working to address gender-based violence and abuse have ignored the plight of older women. As a result, until very recently older women have not accessed emergency housing and community-based women's services, thinking they were exclusively for younger women.

Professionals in gerontology and geriatrics have been primarily concerned with the relationship of abuse in later years to issues of dependency and caregiver stress, ignoring the gender-based aspects of violence and abuse. This scientific-professional approach to abuse in later life, as with child abuse, implies an overriding construct of old age as denoting a state of dependency. This is reflected in legislation and professional practice with respect to elder abuse, which in many jurisdictions has adopted patterns of practice and institutions previously established in child abuse services.[11,12] Neither a feminist approach which in the past has ignored older women, nor a dependency model which ignores gender, will meet the real needs of older women. One is ageist, the other sexist and ageist.

Older Women and Health Professionals

Older women may experience physical, emotional, sexual and financial abuse

and denial of human rights, and various combinations of these. Possible indicators of abuse include inadequately explained accidental injuries, vague chronic health complaints and symptoms of depression or confusion. Abuse victims may mention having limited social contact outside the home, and may refer to their partner's or children's anger, temper or controlling behaviours. They may show signs of nervousness and fear when a partner or family member is present, while such a person may show anger or irritability toward the victim and may assume inappropriate decision-making roles. These and other possible indicators are summarized in Table 2.

An older woman visiting her family physician presenting with vague symptoms of ill health or some of the signs noted above is possibly a victim of intimate partner violence or violence and abuse from another family member. Her life history may include one or more of the elements listed in Table 1. If she is experiencing abuse and violence, it is not gender-free nor necessarily only age-specific. When a physician-patient relationship with an older woman has extended over a substantial period of time, she probably trusts her physician and his or her advice. Women in their 70's and older were brought up in an era in which physicians had more status and trust. Physicians were cited in anecdotal information collected from older abused women in several studies as being a person that they trusted and in whom they would confide.[6,14,15] Even if an older woman denies the abuse, she can be made aware that help is available. The next time, she might share the problem or make use of any information in posters or handouts in a waiting room. Public service advertising campaigns, such as "know the symptoms of stroke and heart attack" and "there is no shame" in having a prostate cancer examination, show that general community awareness is an essential complement to physicians' interventions in our collective health. An information poster or handout on preventing violence and abuse can fulfill the same role.

Hearing from a patient that she is in an abusive situation does not necessarily mean that a physician has to take action to solve the situation. Very few physicians will be as well qualified as others in the community to advise an abuse victim about safety planning and support services. Clearly, it is important that an older woman understand that she is not alone and that abuse can happen to anyone at any age. Even if she denies the fact of her abuse, she will know that there is an avenue to seeking help. She may seek help on her own, and she may disclose at a later time. Older women who disclose to physicians and associated professionals do so because they trust them. Table 3 suggests three of many ways to raise the subject.

Research shows that older women are less likely to report abuse, seek help or use the services of a woman's emergency shelter.[6,14] Shame and humiliation about being a victim may keep a woman from revealing that her spouse, child or other family member abuses her. Victims may fear further abuse or having to make changes late in life, financial realities and poverty. There may be guilt if the abuser cannot take care of himself, religious beliefs about marriage and the outdated precept that problems within the family must stay within the family. These are just some of the factors that may impede an older woman reaching out for help.[16,17] Community-based women's services, such as women's shelter staff, are accustomed to talking through such issues with clients. They are there to support and offer options, not to lead clients to a preconceived answer.

Barriers that impede a health care professional's ability to recognize and assist an abused older woman, as suggested in the literature,[18] include insufficient knowledge, confidence or understanding to identify abuse and its long-term effects, inadequate screening procedures, professional time constraints and lack of knowledge of available community support services. Some of these are improved through practice, some

Table 3: A Sample of Questions on Possible Abuse

Context	Possible Preface	Sample Questions
Ensure absolute privacy	"As our feelings of well being and safety impact on our health, I do ask my older patients a few questions about their daily life."	"Do you feel safe at home?"
Ask questions directly		"Has anyone close to you tried to hurt you or harm you physically or harm you physically or emotionally?"
		"Who makes the decisions about your daily life? Things like what you do and where you live?"

The wording of the question is not what is important–what is important is that the patient be asked in words the physician is comfortable using and that the patient understands.

through a phone call for a supply of brochures and information pamphlets, and some will require research. The medical research depends initially on physicians using what they know at their present state of knowledge to make and act on clinical observations. Physicians' literature includes some advocacy of screening for domestic abuse.[18-20]

Conclusion

Violence against older women is a social and health problem. Health care professionals can be instrumental in identifying this problem. Understanding the gender aspects of violence and abuse, at all ages, helps in identifying the problem. Age-related factors, combined with safety considerations and social and cultural factors, inhibit older women from seeking help. Through active listening, screening questions and monitoring for physical and psychological characteristics, physicians and other health professionals can improve older women's lives by believing and encouraging victims to find help and support.

Those practising in the field of elder abuse have worked hard to identify abuse, to help victims and to raise public awareness. To better serve older women we need a broader framework of theory, research, analysis and practice incorporating factors of gender-based violence, including the dynamics of power and control. ◆

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References

1. Dunlop BD, Rothman MB, Condon KM, et al. Elder abuse: risk factors and use of case data to improve policy and practice. Journal of Elder Abuse and Neglect 2000;12: 95-122.
2. Crichton SJ, Bond JB, Harvey CD, et al. Elder abuse: Feminist and ageist perspectives. Journal of Elder Abuse and Neglect 1999;10:115-30.
3. Lachs MS, Williams C, O'Brien S, et al. Risk factors for reported elder abuse and neglect: Nine year observational study. Gerontologist 1997;37:469-74.
4. Lithwick M, Beaulieu M, Gravel S. The mistreatment of older adults: perpetrator-victim relationship and interventions. Journal of Elder Abuse and Neglect 1999;11:95-112.
5. Brownell P, Berman J, Salmone A. Mental health and criminal justice issues among perpetrators of elder abuse. Journal of Elder Abuse and Neglect 1999;11: 81-94.
6. Hightower J, Smith MJ, Hightower H. Silent and invisible: a report on abuse and violence in the lives of older women in British Columbia and Yukon. Vancouver: BC Yukon Society of Transition Houses, 2001.
7. Krug EG, Dahlberg LL, Mercy JA, et al, editors. World report on violence and health. Geneva: World Health Organization, 2002
8. Lachs MS, Williams CS, O'Brien S, et al. The mortality of elder mistreatment. JAMA 1998;280:428-32.
9. Johns Hopkins University School of Public Health. Ending violence against women. Population Reports, Series L, Number 11, December 1999.
10. Heise L. Violence against women: the hidden health burden. Washington:World Bank Discussion Paper, 1994.
11. Sacco VF. Elder abuse policy: an assessment of categoric approaches. In: Roesch R, Dutton DG, Sacco VF, editors. Family violence: perspectives on treatment, research and policy. Burnaby: BC Institute Against Family Violence 1990, 113-34.
12. Vinton L. Battered women's shelters and older women: the Florida experience. Journal of Family Violence 1992;7:63-72.
13. Pritchard J. Needs of older women: services for victims of elder abuse and other abuse. Bristol: The Policy Press, 2000.
14. Sargent M, Mears J. Older women speak up. Campbelltown, NSW: University of Western Sydney, 2000.
15. Older Women's Long-Term Survival Society of Calgary, McCullough A. A handbook for older women who have survived abuse. Calgary: the Society, 2000.
16. Brandl B. Developing services for older abused women: a guide for domestic abuse programs. Madison: Wisconsin Coalition Against Domestic Violence,1997.
17. Hightower J. Smith MJ. Silent and invisible what's age got to do with it? A handbook for service provider working with older abused women. Vancouver: BC Yukon Society of Transition Houses, 2001.
18. Mouton CP, Espino DV. Health screening in older women. American Family Physician 1999;April:1835-42.
19. Fisher JW, Dyer CB. The hidden health menace of elder abuse: Physicians can help patients surmount intimate partner violence. Postgrad Med 2003;113:21-4.
20. Punukollu, M. Domestic violence: Screening made practical. Journal of Family Practice 7/1/2003.