When an elder is the abuser

Improving the recognition and management of domestic violence among elderly couples

Separate paradigms and services for elder abuse and domestic violence raise the concern that intimate partner violence in older couples is under-recognised (Box). These paradigms are associated with age-specific characteristics, with very different implications for management when compared with younger age groups. In addition, there is also a higher risk of death in older domestic violence victims compared with younger people and in incidents involving strangers.[1]

The neglect in this area can be attributed to two main reasons. First, our understanding of elder abuse does not easily accommodate a focus on physical violence perpetrated by elderly people against an intimate partner. The paradigm of elder abuse views the elder as vulnerable and frail, characteristics that are perceived to be intrinsic to advanced age. In most cases of elder abuse, the elder is prey to a younger aggressor — 60% of perpetrators are children and less than 10% are a spouse or partner.[3] Neglect, psychological and financial abuse are more common and, therefore, tend to be emphasised over physical abuse by elder abuse information sites.[4]

Second, domestic violence guidelines have not highlighted the specific needs of older people. In contrast, there has been a focus on the additional challenges in accessing services faced by people who are Indigenous, from a culturally and linguistically diverse background, or experiencing a disability.[2]

Domestic violence perpetrated by an older person requires clinicians and families to consider a different narrative to that predominant in elder abuse, one where the elder is the aggressor and may have been so for decades. Indeed, Australian data have indicated that 14% of homicides involving victims aged 70 years or over, so-called eldercide, were committed by an intimate partner.[5] We also believe it is important to recognise that over 40% of older victims of domestic violence-related assaults are men and that such violence can be perpetrated by women or be bidirectional.[6]

Probable under-reporting and under-detection

The true frequency of domestic violence perpetrated by older people is unknown, as research essentially excludes older age groups. For instance, the Australian Bureau of Statistics Personal Safety Survey[7] grouped all older people who had experienced violence into one group aged 55 years and over, yet entry to aged care services starts at 65 years of age.

Data from the Personal Safety Survey showed that 0.4% of older women aged 55 years and over reported partner violence involving physical assault or threat, and sexual assault or threat. Yet, the rate of reporting of domestic assaults to New South Wales police between 2001 and 2010 was lowest in those aged 50 years and over, with only 28% of victims reporting the incident to police.[8]

Under-reporting may be even higher in women in their seventh and subsequent decades of life. This cohort of older women came of age at a time when attitudes to gender were vastly different, violence within a marriage did not carry the social opprobrium or the potential for criminal charges that it does now, and there were few resources available to support a woman who wished to leave a marriage. Factors specific to under-reporting by older women include being a grandmother and ageing, which seem to accentuate the reluctance to fracture family relations.[9]

Professionals face additional barriers to enquiry of domestic violence in older people. There may be a lower imperative to enquire about domestic violence owing to assumptions that an older partner lacks the ability to cause physical harm and because of the absence of dependent children at home. The physical signs of domestic violence may be all too easily explained in older people as the result of frailty or a fall.

In addition, there is an important group of older people for whom domestic violence is not usually recognised as such — those who develop behavioural and psychological symptoms associated with dementia.

Aggression exhibited by people with dementia has instead been viewed as intrinsic to neurodegeneration, and the perpetrator as lacking insight into their actions, particularly when there has been no premorbid history of

Definitions

Elder abuse: Acts of omission or commission that result in psychological, physical, financial or sexual harm to an older person, and is perpetrated by a person in a position of trust.[1]

Domestic violence: Acts of physical, sexual, and psychological abuse among people in current or previous intimate relationships.[2]

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interpersonal violence. While we do agree with this approach of not routinely classifying aggressive behaviours associated with dementia as a form of domestic violence, it is still important to consider the possibility of a history of violence earlier in the relationship. This highlights the need for a more nuanced approach that integrates an understanding of the longstanding characteristics of a perpetrator and the dynamics of a couple with later onset of neurodegeneration.

Clinical presentations

Most intimate partner violence in older couples is domestic violence "grown old". The study of older couples by Lanzebatt and colleagues[10] found that the mean duration of domestic violence was 39 years.

In many cases, physical violence may decline or cease as the couple grows older, only to be replaced by emotional abuse and threats of abandonment. It is usually the growing frailty of the victim that finally leads to the call for help. Another pattern that may be seen is a reversal of a longstanding victim–abuser relationship due to physical illness or cognitive impairment in the perpetrator. This change in dynamic may lead to the person who was once the victim of violence becoming the abuser. Along with a higher general level of aggression and controlling behaviour, alcohol misuse is one of the strongest risk factors for intimate partner physical violence[11] and may persist into late life.

In contrast, late onset domestic violence tends to follow the development of cognitive impairment in a perpetrator, resulting in executive dysfunction with an inability to control impulsivity. It has been estimated that 24% of community-dwelling people with dementia demonstrate agitation or aggression, which is four times greater than for age-matched peers without dementia.[12] Delusional jealousy, a conviction about the infidelity of one's spouse, occurs in 9% of people with dementia and may be associated with aggression.[13] This was the most common delusion in the 19% of older domestic homicide offenders with psychosis in NSW.[14]

Management suggestions

The first step is to understand that framing all abuse of older people as "elder abuse" fails to recognise that older people can be perpetrators, as well as victims, of domestic violence, and that a long history of violence and complex interpersonal dynamics may exist. Our primary concern is that such violence in an older couple runs the risk of straddling, yet is not fully encompassed by, elder abuse and general domestic violence services.

Health providers, in particular general practitioners, should be mindful of the ongoing risk of domestic violence in an elderly couple with a history of intimate partner violence, especially in the setting of alcohol misuse or dementia. Although routine screening of women aged 16 years and over for domestic violence is mandatory in most jurisdictions, its benefits remain controversial.[15] The six-item Elder Abuse Suspicion Index may be used as a general screening tool (http://www.nicenet.ca/tools-easi-elder-abuse-suspicion-index), which may be supplemented by specific questions about intimate partner violence if such concerns arise.

When domestic violence is suspected in an elderly couple, the risk of serious harm to the victim should be assessed first. Assessment of the perpetrator should focus on excluding psychosis and cognitive impairment. Additional management measures will then depend on the specific characteristics of the perpetrator.

For late onset domestic violence associated with dementia or psychosis in the perpetrator, an initial referral to community old age psychiatry services for behavioural and pharmacological management is recommended. Under the relevant Mental Health Act or Guardianship Act, as appropriate to the individual jurisdiction, hospitalisation for acute treatment may be necessary in more urgent cases. In certain circumstances, another appropriate option is respite accommodation in a residential aged care facility; should the risk persist, permanent placement may be essential.

Longstanding cases, where the characteristics of the couple are no different from those in younger people, tend to be managed via standard pathways. This is problematic as there is a dearth of age-appropriate crisis and case management services. Shelters currently cater for the needs of younger women and their children, and would need to be modified for the physical and cognitive needs of older women or be purpose built.

In both cases, an important difference in managing domestic violence in this age group is that the perpetrator may be a carer. Here, separation of a couple will require a coordinated community response, involving social, health care and accommodation services to support the victim.

In conclusion, it is important to conduct a study specific to older male and female Australians' experience of intimate partner violence. Elder abuse helplines need to highlight physical violence by an intimate partner as much as financial abuse or child neglect. Existing domestic violence helplines and services should train staff in the specific needs of older people to be able to triage and provide initial management to an older victim of domestic violence. First responders need to be aware that the elderly, like children, are particularly vulnerable to serious injury or death from violence, and that domestic violence in older people may occur in an age-specific context that is not criminal.

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