Abuse in Later Life: Power and Control Dynamics and a Victim-Centered Response

Deb Spangler and Bonnie Brandl

Too often, older, women are abused, neglected, and exploited. In cases where the older victim and perpetrator have an ongoing relationship, power and control dynamics like those used against younger battered women are often present. In these cases, a victim-centered response and some strategies used with younger victims of domestic violence may be most effective in promoting safety and ensuring support and services. To assist mental health professionals and psychiatric nurses, this article focuses on three main topics: the dynamics of abuse in later life, a victim-centered response, and working collaboratively with other disciplines to offer a comprehensive response to these complex cases. ***J Am Psychiatr Nurses Assoc, 2007; 12(6), 322-331. DOI: 10.1177/1078390306298878***

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Mabel (age 68) is a frequent user of the health care system and has a thick file. She has been in and out of the hospital with various vague complaints of headaches, chest pains, and stomach problems. She has also received inpatient and outpatient mental health services over the years. She has experienced anxiety attacks and depression, which do not improve with medication and/or therapy. Mabel never shares with health care providers that her husband has been physically abusive and extremely controlling throughout their 50-year marriage.

Lucille (age 80) was recently admitted for inpatient psychiatric services. Lucille is withdrawn and appears suicidal. Lucille has not told staff that her 57-year-old son moved back in with her recently following his divorce and that he has been sexually assaulting her.

Reports of elder abuse like those above are increasing throughout the country (National Center on Elder Abuse, 2006). As the population, specifically the baby boom group, ages, reports of abuse are expected to increase. 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).

A significant portion of elder abuse involves an older victim who is in an ongoing relationship with the abuser, such as spouse/partner, adult child or other family member, or caregiver (National Center on Elder Abuse, 1998). Zink and Pabst (2005) found that intimate partner violence in later life occurs less frequently than with younger women but that it still occurs with enough frequency that health care providers should screen older women for domestic violence. Elder sexual abuse is often perpetrated by family members such as adult sons or spouse/ partners (Ramsey-Klawsnik, 2003). Using the National Violence Against Women Survey, Jasinski and Dietz (2003) also found domestic violence and stalking victimization was only slightly lower among women age 55 and older than younger women. In many of these cases, the perpetrator is using a pattern of coercive tactics to gain and maintain power and control in the relationship or to financially exploit the victim (Brandl, 2000; Dunlop, Rothman, Condon, Hebert, & Martinez, 2000; Pillemer & Finkelhor, 1988). Given the unique dynamics that occur in these cases, this article focuses on this subset of elder abuse and does not discuss scams/harm by strangers or self-neglect.

Heath care professionals, such as nurses and mental health service providers, are in a unique position to identify and address the needs of older victims of abuse. Addressing the root of a patient's

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problem rather than solely treating the presenting symptoms can lead to more efficient and effective mental health care services and improvement in the lives of victims (Brandl & Horan, 2002).

This article focuses on three main topics: the dynamics of abuse in later life, a victim-centered response, and collaboration. The dynamics of abuse section covers (a) defining domestic abuse in later life, (b) describing why abuse occurs and debunking common misconceptions about causation, (c) identifying consequences of abuse, and (d) discussing common barriers victims experience that make it difficult for them to live free from abuse. The victim-center response section highlights (a) recognizing indicators, (b) screening, (c) offering hope and support, (d) providing information and referrals, (e) planning for safety, and (f) reporting. Given the complexity of these cases, the final section focuses on collaboration between domestic violence, mental health, adult protective services, aging network, and other professionals.

THE DYNAMICS OF ABUSE IN LATER LIFE

Defining Abuse in Later Life

For the purposes of this article, abuse in later life describes older victims in an ongoing relationship with an abuser who is using a pattern of coercive tactics to gain and maintain power and control in the relationship or financially exploit the elder. The key components of this definition are as follows:

- Age: Victims are age 50 and older. Perpetrators are any age.
- Gender: The majority of victims are female, especially in cases of physical and sexual abuse (Crichton, Bond, Harvey, & Ristock, 1999; Jasinski & Dietz, 2003; Lithwick, Beaulieu, Gravel, & Straka, 1999; Vladescu, Eveleigh, Ploeg, & Patterson, 1999).
- Ongoing relationship: Spouses, partners, adult children, other family members, and caregivers can all be abusers who use a pattern of tactics to harm their victims. Spousal relationships or partnerships may be long term—for example, marriages that have lasted 50 years or more. Some are new relationships, often following the death or divorce from a previous partner. The abuse may occur throughout the relationship or be a relatively new occurrence.
- Power and control dynamics: Similar to those used against younger battered women, older individuals may experience a pattern of tactics to gain and maintain compliance (Schechter, 1987). These tactics can be used not only by intimate partners but also by other family members and some caregivers.

Power and Control Dynamics

Researchers and practitioners have recognized over the past decade that the dynamics of abuse in later life in many cases are often very similar to those experienced by younger battered women (Harris, 1996; Pillemer & Finkelhor, 1988; Podnieks, 1992; Wolf, 1998). Most often, abusers have entitlement thinking patterns—they believe they have special status and that it provides them with exclusive rights and privileges that do not apply to others (Bancroft, 2002). They use various tactics to gain and retain control of their victims, often by setting the rules for the living arrangements—such as the time of dinner, what is watched on television, who the victim talks to, and where the older adult goes (Bancroft, 2002). Abusers' thinking patterns lead them to believe their needs and wants are more important than others in their lives and that they can use any method necessary—for example, stealing from a grandparent if they need money or forcing a spouse to have sex if they desire sexual contact or want to dominate or humiliate their partner.

The National Clearinghouse on Abuse in Later Life, a project of the Wisconsin Coalition Against Domestic Violence, created the Abuse in Later Life Wheel (2006) (Figure 1) by working with more than 50 older women attending support groups in eight states throughout the country. Like the Duluth Power and Control Wheel created more than a decade ago, this wheel illustrates tactics used by abusers against older women.

The older women who participated in this project felt that power and control over their lives was the central reason why the abuse occurred. These women experienced threats, intimidation, isolation, and other forms of abuse seen on the wheel. In particular, they noted a significant amount of emotional and psychological abuse interwoven with other abuser tactics—which can be seen on the wheel listed between each pie piece.

Situations Where Power and Control Dynamics Are Not Present: Other Explanations and Excuses for Abuse in Later Life

Many cases of abuse in later life involve power and control dynamics. In rarer cases, several other explanations for abuse are worth noting because intervention strategies are significantly different in these cases. In fewer cases, the perpetrator has a physical or mental condition that manifests itself in

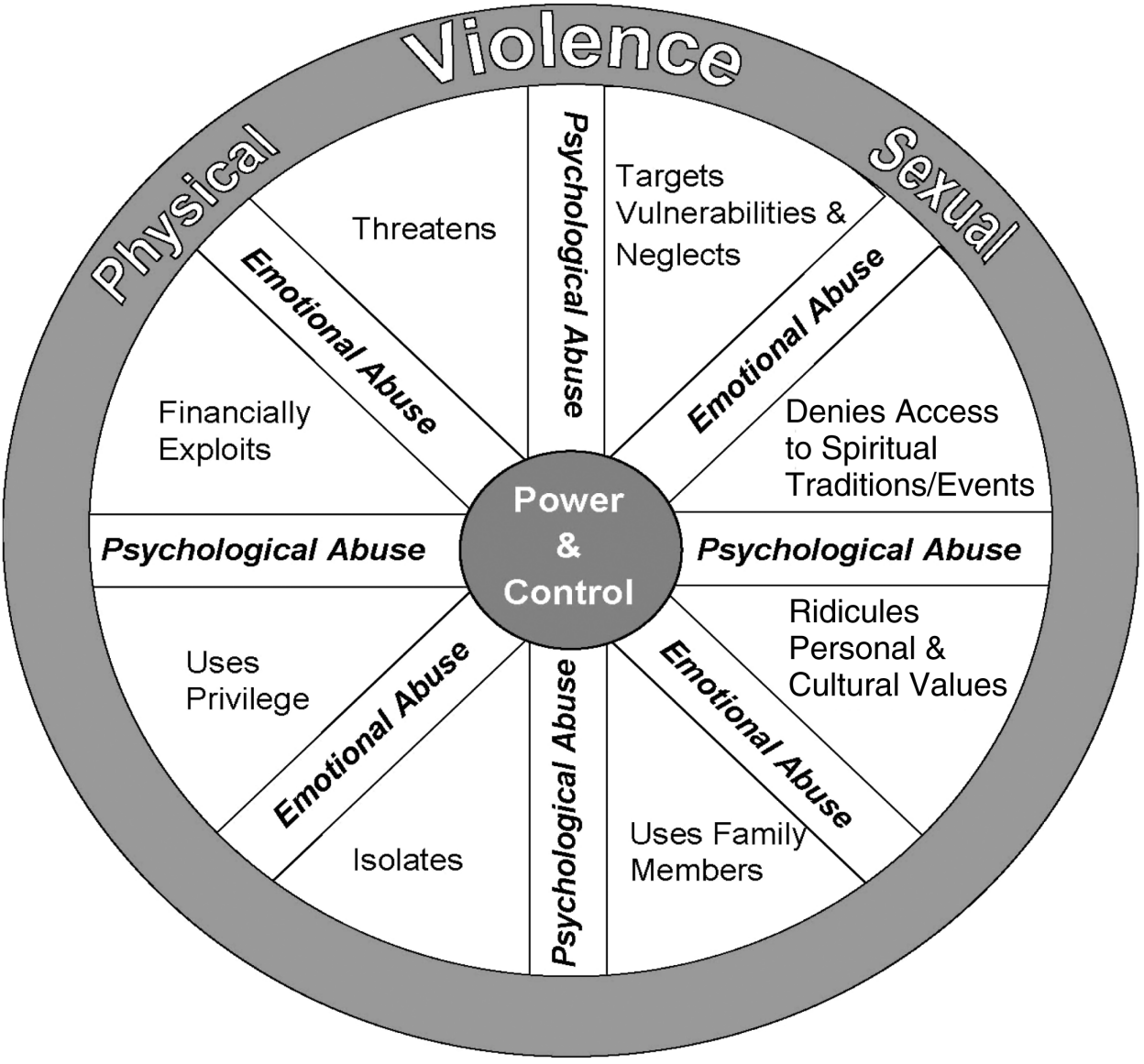

FIGURE 1. Abuse in Later Life Wheel.

Source: Reprinted with permission from the National Clearinghouse on Abuse in Later Life, a project of the Wisconsin Coalition Against Domestic Violence, Madison. This diagram adapted from the Power and Control/Equality wheels developed by the Domestic Abuse Intervention Project, Duluth, MN. Permission to adapt 2006.

challenging, aggressive, often abusive or sexually inappropriate behaviors. In these situations, such as some individuals with Alzheimer's disease—where power and control dynamics are not present—the adults who are harming another person are not able to control their actions, and therefore arrest and counseling programs are not effective. However, instances in practice have shown that offenders may make claims of medical condition when in fact their abusive tactics reflect more typical issues of power and control.

In addition, there are some cases in which a well-intended caregiver is unable or lacks the knowledge to provide adequate care. For example, a 90-pound woman may be physically unable to turn her 200-pound husband who is unable to get out of bed. An adult child with developmental disabilities may not be able to manage his parents' medication schedule. In these situations, power and control dynamics are not present even though abuse and harm may be occurring. Additional training and services are the most effective responses.

Abusers and professionals may have additional explanations or excuses for abusive behavior. Various issues, such as anger, substance abuse, or caregiver stress frequently do co-occur with abuse in later life but should not be misconceptualized as the cause of abusive behaviors. Reis (2000) found that the following do *not* have a basic linkage to abuse in later life: feelings of stress, dependence on family or others, cognitive or physical impairment, or financial difficulties. The Indicators of Abuse Form was created in Canada by having professionals test the tool on 341 cases. Researchers validated 29 items that could together identify abuse cases 78% to 84.4% of the time. Caregiver indicators included behavior problems, financial dependency, and tendency to blame others. Care receiver indicators included a history of abuse, social isolation, and suspicious falls/injuries (Reis, 2000.)

Caregiver stress is often conceptualized as an explanation for abuse in later life. In the 1980s, caregiver stress was often described in the literature as a primary cause of elder abuse, and some recent articles continue to promote this notion. This theory postulates that caregivers experience such high levels of stress caused by the demands of providing care that they lash out at older individuals and harm them (Steinmetz, 1988). Despite the popular belief 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, p. 9). In fact, rather than the elder being dependent on the caregiver or family member, studies suggest that in many cases the abuser is dependent on the victim (i.e., financially or emotionally) (Pillemer & Finkelhor, 1989; Seaver, 1996; Wolf & Pillemer, 1997). Often, the victim and abuser are living together and it is the older victim who is providing the financial resources for food, clothing, and housing and taking care of the home.

Misunderstanding the relationship between caregiver stress and abuse can be dangerous for the victim. Too often professionals intervene in abuse cases by focusing on the caregiver/abuser's identified level of stress. Remedies to alleviate the stress may include support for the abuser, respite care, or counseling. Although these interventions may reduce the caregiver's stress, the victim may remain in danger and harm's way. None of the stress-reduction remedies focuses on victim safety—which should be the primary mission of any abuse case. In fact, counseling for the abuser can actually increase the risk for the victim, who may return home or have increased contact with him because she believes he is going to change (Gondolf, 1988). In addition, couples or family counseling may also be recommended to reduce stress and improve communication. Couples or family counseling can put some victims at increased risk and is contraindicated in some situations (Bograd, 1999). Practitioners working with battered women have heard from victims that their abusers have harmed them in the parking lot of health care settings or within 24 hours of counseling or health care appointments.

Consequences of Abuse

In cases of abuse within the context of a long-term relationship, the consequences to victims can be significant. Many older victims frequently have longer recovery periods and higher mortality rates stemming from physical injuries that occurred as the result of physical violence or sexual assault. Lachs, Williams, O'Brien, Pillemer, and Charlson (1998) found that reported and corroborated cases of elder mistreatment are associated with shorter survival after adjusting for other factors that are linked with increased mortality in older adults. This study followed 2,812 community-dwelling adults aged 65 and older that included a subset of 176 persons who were seen by elderly protective services for verified allegations. At the end of a 13-year follow-up period, those who were seen by protective services had a poorer survival rate than the general population (Lachs et al., 1998). In addition, financial resources that have been stolen through exploitation may be difficult or impossible to recover. Years of psychological abuse can lead to victims not trusting their own judgment or instincts. Abusers often use tactics to isolate their victims—leaving some older victims to be alone without the love and support of caring friends and family.

Little research has been conducted on mental health consequences of elder abuse. However, studies on younger battered women provide useful information when working with older victims. "Although the majority of abuse survivors do not develop psychiatric disorders, victimization by an intimate partner does place women at much higher risk for depression, anxiety, post-traumatic stress disorder, substance abuse, and suicide attempts" (Warshaw, Gugenheim, Moroney, & Barnes, 2003, p. 230). There is a growing body of clinical evidence in studies done on younger victims that indicates that experiencing abuse plays a significant role in the development

and exacerbation of mental disorders and substance abuse problems, increases the risk for victimization, and influences the course of recovery from a range of psychiatric illnesses (Domestic Violence and Mental Health Policy Initiative, n.d.). On average, more than half of women seen in a range of mental health settings are either currently experiencing or have experienced abuse by an intimate partner (Domestic Violence and Mental Health Policy Initiative, n.d.).

Barriers Victims Face to Living Free From Abuse

Older victims often face significant barriers to seeking help and living free from abuse. Beaulaurier and Seff (2005) found six key factors for older abused women that were barriers to help-seeking: self-blame, powerlessness, hopelessness, the need to protect the family, and the need to keep the abuse a secret from others.

Some older victims chose to continue contact with their abusers for various reasons. Older 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 older victims fear retaliation, and, in fact, anecdotal evidence suggests that some victims are at greatest risk of being seriously harmed or killed when they seek help or attempt to leave the abusive relationship. Zink, Jacobson, Pabst, Regan, and Fisher (2006) found that older women who stayed with abusers used emotional and problem-focused strategies that impacted their survival and improved their lives. The researchers interviewed 38 women ages 55 and older. Their findings showed that many women who stayed with abusers were able to refocus their energy into specific roles, set limits with the abusers, and reach out to others. "Some women appeared to thrive, others merely survived, but all maintained the appearance of conjugal unity" (Zink et al., 2006, p. 634).

Battered women who leave abusers typically go through several shifts in thinking that involves both material and psychological factors before making their final decision (Anderson & Saunders, 2003). Leaving an abuser can be a process where women focus on their safety needs and are concerned about those they love. They consider the values of marriage, family, and their role as wife and mother. Older battered women also explore the financial and practical realities of leaving an abuser, such as where they will live and how they will pay for insurance and medications. In addition, on a macrolevel, society has often ignored the needs of older abused women, therefore limiting the options available to them (Buchbinder & Winterstein, 2003). Ending a spouse partner relationship can be difficult. For older victims abused by adult children, ending the relationship may never be a real option for many victims. They may cut off contact for a period of time, only to try to reestablish the relationship after a few weeks, months, or years. Advocates working with older abused women have suggested that those who leave an abuser often are in greater danger or have access to greater financial resources.

A VICTIM-CENTERED RESPONSE

A number of parallels exist between domestic violence (as experienced by younger victims) and abuse in later life. First, abusers of both populations use similar tactics of power and control with their victims. The abusers often use similar tactics to achieve their goals. Second, victim reactions such as fear, anxiety, depression, and lack of confidence in their own abilities are common in both groups. Given these commonalities, strategies that have been found to be effective with younger battered women can be tailored to meet the needs of and empower older victims of abuse (Dunlop et al., 2000; Lundy & Grossman, 2004; Ramsey-Klawsnik, 2000). The National Clearinghouse on Abuse in Later Life has worked with domestic violence and aging network programs in Wisconsin and throughout the country, which are working directly with older victims and offering various services. These program providers advocate a victim-centered approach when working with victims of abuse in later life. Hightower, Smith, and Hightower (2006, p. 205) found that older women, like younger victims, need "a safe environment, emotional support, advocacy, information and peer support."

A victim-centered approach focuses on the safety needs of the older individual. The victim is the primary client, not the entire family. The victim works with professionals to create a plan that works for her (Hightower et al., 2006). Information about the dynamics of abuse and available services are provided to the victim so she can make an informed choice about next steps. A victim-centered approach recognizes that individuals are the best judges of their own safety and risk. Victims are neither encouraged nor discouraged to remain in the relationship or leave the abuser. This approach promotes giving the victim permission to make the decision that is right for her about continuing or ending the

relationship. Many women want to continue to have a relationship with their abusers; they simply want the abuse to end. For those women who leave the relationship, often it can be a process of leaving and returning. Within a victim-centered approach, the victim's needs consistently remain the highest priority in planning care. This approach contrasts the medical model, where professionals make an assessment or diagnosis and outline a plan for the patient. Rather, a victim-centered model is a partnership with the victim, where professionals are careful not to use their power in the relationship as abusers do—by telling the victim what to do and how to live. Rather than focus on deficits or vulnerabilities, a victim-centered model builds on the strengths, abilities, and successes of the victim (Gondolf, 1988).

A victim-centered approach starts with abuse recognition and identification. Many older victims will not self-disclose. However, key questions and formal screening instruments can be used to facilitate case identification. If abuse is disclosed, supportive messages, information, referrals, and safety planning are all crucial interventions. Finally, a report to adult protective services or law enforcement may be required if determined appropriate. The next section briefly highlights these key components of a victim-centered approach as practiced by many advocates and professionals working with older women.

Indicators of Abuse in Later Life

Recognition of victims' and abusers' behavioral indicators are critical to identification of domestic abuse in later life. Abusers often lie, manipulate, and blame others for their behavior. Abusers often try to manipulate and charm professionals so they will not be held accountable (Salter, 2003). Because abusers may lose their freedom, reputation, financial resources, housing, and their access to the victim if the abuse is discovered, some victims may be hesitant to disclose abuse and abusers may minimize or deny their behavior. Table 1 provides examples of victim and abuser behaviors that may be indicative of abuse in later life.

Any indicator on its own does not mean abuse is occurring. Generally, a cluster of these behaviors warrants further investigation into possible abuse. Harm may also be occurring even if none of these indicators is present.

Screening for Abuse in Later Life

Too often, screening questions are not being asked of adults over 60 years of age. Mental health providers may treat older adults differently and therefore miss evidence of abuse or may only consider domestic abuse by an intimate partner but fail to recognize an abuser who is an adult child, family member, or caregiver.

To increase identification of elder and domestic abuse, mental health providers should adopt routine screening for all patients over 60 years of age. Often, victims will not disclose abuse until trust has been established with the service provider. If abuse is not disclosed, screening questions should be asked at subsequent appointments. Prior to assessment, patients should be advised that disclosure of abuse might prompt mandatory reporting to law enforcement and/or adult protective services.

Screening questions should be asked in private, out of sight and hearing of anyone accompanying the older adult, so that answers may be given freely without fear of reprisal. Use of gender-neutral language when screening for abuse is recommended until the relationship to the abuser is identified by the patient.

A reliable interpreter who is not related to the patient should be available for non-English-speaking patients or patients who are deaf. If screening cannot be done privately or an interpreter is not available, screening should be postponed until a later time.

The Abuse in Later Life Wheel (Figure 1) can be used to help a patient identify abusive tactics that have been used against them. Assure the patient that because abuse is common, all patients are asked about abuse in their lives.

Examples of screening questions are the following:

- How often do you go out with friends?
- Are you afraid of anyone?
- Has anyone close to you tried to hurt you recently?
- Has anyone close to you called you names, put you down, or made you feel bad recently?
- 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?
- Has anyone taken things that belong to you without your permission? (Bomba, 2006)

During interviewing or screening, signs of compromised cognitive functioning may be present, and more extensive cognitive evaluation may be warranted. However, in some cases the symptoms

TABLE 1. Victim/Abuser Behaviors

A Victim May	An Abuser May
Have injuries that do not match the explanation of how they occurred	Minimize or deny the victim's injuries or complaints
	Attempt to convince others that the victim is incompetent or crazy
Have repeated "accidental injuries"	Blame the victim for being clumsy or difficult
Appear isolated	Physically assault or threaten violence against the victim or victim's family, friends, pets, or the worker
	Isolate the victim, prevent outside activities and contacts
	Threaten or harass the victim
	Stalk the victim
Say they are, or hint at being, afraid	Act overly attentive toward the victim
Give coded communications about what is occurring	Act lovingly and compassionately to the victim in other people's presence
Consider or attempt suicide	Consider or attempt suicide
Have a history of alcohol or drug abuse (including prescription drugs)	Have a history of alcohol or drug abuse
Present as a "difficult" client	Refuse to allow an interview with the victim to take place without being present
	Speak on behalf of the victim, not allow the victim to participate in the interview
Have vague, chronic, nonspecific complaints	Say victim is incompetent, unhealthy, or crazy
Be emotionally and/or financially dependent on the abuser	Be emotionally and/or financially dependent on the victim
Miss appointments	Cancel the victim's appointments or refuse to provide transportation
Delay seeking medical help	Take the victim to different doctors, hospitals, and pharmacies to cover up abuse
	Refuse to purchase prescriptions, medical supplies, and/or assistive devices
Exhibit depression (mild or severe)	Turn family members against the victim
	Talk about the victim as if he or she is not there or not a person (dehumanize victim)
Exhibit evidence of effects of stress and trauma	Any or all of the above

Source: Brandl et al. (2006).

are the result of victimization rather than dementia. Indicators such as poor judgment, confusion, lethargy, and inability to communicate can mimic signs of dementia. However, these symptoms improve significantly within a few days when the victim has had food, proper doses of medication, and sleep in a safe environment. If compromised cognitive functioning is substantiated, a local adult protective services agency will provide consultation regarding services available.

Messages of Support and Hope

Asking about abuse itself is a powerful intervention, as it communicates to older victims that their abuse experiences can be discussed with service providers. Kind supportive words of encouragement and referrals provide concrete options and support, even if the older victim does not take action immediately.

Older abused adults often feel powerless about their lives and may be confused by the messages given to them by the abuser or others. In many cases, they want to maintain the relationship but want the abuse to stop, particularly if the abuse is perpetrated by an adult child.

If abuse is disclosed, nonjudgmental and supportive messages are essential. Compassionate messages acknowledging that the abuse is not the victim's fault and recognition of the courage needed to talk about these personal matters are also important. Avoid asking questions that blame the victim for the abuse such as, "Why do you stay?" "Why don't you just leave?" or "What did you do that made him hit you?"

Providing Information and Options

In cases of abuse in later life, often abusers seek to control the older victim's life and decisions. Therefore, use of an empowerment framework is

critical. In this framework, information and referrals are provided and victims are supported to develop their own plans, based on their goals and needs. Some victims will choose to maintain contact with or continue to live with their abuser. In these situations, strategies to break isolation and promote victim safety are important. Victims who choose to end the relationship may need financial resources, housing assistance, and ongoing support.

There are a number of specific services that may be useful referrals. Support groups for older abused women or victims of domestic violence can be very helpful (Brandl, Hebert, Rozwadowski, & Spangler, 2003). Domestic violence or sexual assault hotlines are available 24 hours to provide support and information by phone (National Domestic Violence Hotline is 1-800-799-SAFE for more information about local programs and 1-800-858-HOPE for local sexual assault services). Legal advocacy can include protective orders, information on immigration laws, and accompaniment through the court process (for more information, go to www.elderabusecenter.org). The aging network, the faith community, and culturally specific groups also offer a number of programs that can break isolation and provide social contacts. To find information about these programs, contact a state unit on aging or local area agency on aging (National State Units on Aging at www.nasua.org or National Association of Area Agencies on Aging at www.N4A.org).

Safety Planning for Older Victims

Safety planning is a specific strategy developed by the battered women's movement to help enhance victims' safety. Professionals work with victims to help them develop specific plans to be implemented if they believe they are in immediate danger, how to deal with an abuser who approaches them in public, and what to take if they need to leave in an emergency. Effective safety plans include responding to both life-generated and abuser-generated risks (Davies & Lyon, 1998). Sample safety planning tools can be found at http://www.ncall.us.

Older victims who have sustained long histories of abuse may have developed strategies over the years that have kept them as safe as possible. Victims are the best judge of what will keep them safe in the future. Safety planning should be victim guided. The plan should be fluid and must be revisited frequently as the abuser tactics change and/or the severity of abusive incidents increases.

Reporting Elder Abuse

All states have a system for reporting elder abuse to authorities such as adult protective services or law enforcement. In most states, mandated reporting is required by either specified professionals or "anyone." All health care providers should know the mandatory reporting laws in their state and the protocols for reporting that are used where they work.

Providers should let patients know the limits of confidentiality prior to initial interviews or assessment. Patients should be told that a report may be made if information regarding abuse is disclosed. For some victims, reporting can provide access to information and services that can be beneficial. For other victims, the report and subsequent investigation can increase the risk of harm because the abuser fears losing access to the victim or being held accountable. Therefore, professionals who are required to report abuse should work with patients to develop a safety plan when abuse is disclosed. Contact information to report elder abuse in each state is available on the National Adult Protection Services Association Web site (www.napsa.org)

COLLABORATION

Increasingly, professionals are recognizing the need for a multidisciplinary response to older victims of abuse due to the complexity of these cases (Brandl et al., 2006; Teaster, Nerenberg, & Stansbury, 2003). Often, elderly abuse cases are complex involving multiple forms of abuse, including physical, sexual, emotional, neglect, and financial exploitation. Victims may experience a variety of physical and mental health needs, aging and disability issues, and violence and trauma reactions. Offenders need to be held accountable for their actions. The following lists some organizations that may be involved in a victim's life and case.

- Advocacy organizations such as domestic violence or sexual assault programs
- Adult protective services that investigats allegations of abuse and offers case management and referrals
- Aging network services, the faith community, and culturally specific organizations that offer support services and programming to break isolation
- Health care system that addresses physical health needs
- Mental health system that responds to mental health needs
- Justice system that works to hold abuser accountable and offers civil remedies

Multidisciplinary and interdisciplinary teams to address elder abuse are being formed throughout the country. Some teams focus on working individual cases collaboratively. In some communities, health care professionals lead teams that focus on neglect and other forms of physical abuse. Other teams work collaboratively to address financial exploitation. To date, few of these teams have partnered successfully with the mental health community.

Collaboration can also occur without formalized teams or meetings. Domestic violence advocates and mental health providers should find ways to work together both for the benefit of victims and practitioners. Historically, domestic violence programs have been designed for younger women, and too few tailored services for older victims currently exist (Fisher, Zink, Pabst, Regan, & Rinto, 2003; Vinton, 1998). Mental health services have also generally focused on the needs of a younger population. Therefore, having both systems working together can improve the array of options available to victims. Some victims will feel safer and more connected with a mental health provider; others will feel more comfortable in an advocacy environment. If clinicians and advocates develop the trust and understanding necessary for good working relationships, they can better help battered women to redefine those boundaries and to be safe, to heal, and to move forward in their lives.

Service providers from both mental health and domestic violence can also benefit from collaboration. Mental health clinicians are less likely to feel overwhelmed by an older victim's need for safety or for help negotiating the legal system if the clinicians are working in partnership with domestic violence advocacy programs. At the same time, having a network of clinicians who can assess the mental health needs of the domestic violence survivor and/or her adult children, provide treatment, or help negotiate the mental health system will only enhance the capacity of domestic violence programs to address the needs of the women they serve (Warshaw & Moroney, 2002).

CONCLUSION

Mental health practitioners and psychiatric nurses have a crucial role to play in abuse in later life cases. By recognizing that the dynamics of abuse in later life are often based on power and control, like those experienced by younger battered women, practitioners can focus on recognizing and responding to older victims. A victim-centered approach, where safety and empowerment of the victim are the primary focus, has been found to be the most effective framework used by many professionals in the field. Finally, collaboration with other practitioners with expertise in abuse, aging, and a variety of issues is crucial. Too many older victims have nowhere to turn and do not know help is available. You can make a difference by recognizing and responding to potential cases of abuse by offering hope, support, information, and referrals.

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