Published in final edited form as:

Patient Educ Couns. 2007 October ; 68(2): 167–172.

Family Violence and Associated Help-Seeking Behavior among Older African American Women

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Abstract

Objective—Little is known about how older African American women define family violence (FV) and what FV survivors might expect from their healthcare providers. The purpose of this study was to understand how these women define FV, where they seek help for FV, and what barriers they face in these efforts.

Methods—We conducted 6 focus groups with 30 African American women over the age of 50, including some FV survivors, at a large, inner-city public hospital.

Results—Participants defined FV broadly, citing examples of abuse (physical, sexual, emotional and financial) and neglect. Spiritual sources were cited over physicians as being available to help FV survivors. Barriers to receiving assistance included negative encounters with physicians, lack of trust in the system and dearth of age-appropriate resources.

Conclusions—For older African American women, FV takes many forms of which many may not be obvious during the clinical encounter. Like younger FV survivors, they expect physicians to serve as a resource for FV.

Practice implications—Physicians caring for older African American women need to remember to ask them about FV, and when making referrals for abuse and neglect, consider offering referrals to pastoral care if appropriate.

1. Introduction

Past or current family violence (FV), an important and common problem experienced by women seen for medical care, is an unrecognized barrier to good patient-physician communication.(1,2) To date, the focus of FV research has been populations of younger women; less attention has been paid to older woman who are FV survivors. While physicians generally are aware of intimate partner violence (IPV) and ask women presenting with injuries

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about ongoing IPV,(3) they may not be as cognizant that FV can affect older women, as illustrated in a recent study of family physicians and general internists, where most respondents did not consider elder abuse (EA) to be a prevalent problem.(4)

Experiences of older women who are victims of FV have been studied as two separate but overlapping constructs: IPV, which is violence experienced by women at the hands of an intimate partner, and EA, which is abuse of older individuals at the hands of a family member, caregiver or stranger.(5) With respect to experiences of older women experiencing IPV, Zink and colleagues used a qualitative approach to *understand* the experiences of IPV among women 55 and over.(6,7) They found that women reported a range of abusive experiences, namely physical, sexual, emotional and financial, similar to forms of abuse reported by younger women. However, unlike younger women, older women had more invested in their families and communities, and felt they had more to lose by leaving the relationship. Another common theme expressed by these participants was that poor health, both theirs and their partner's, often kept them from leaving an abusive relationship.(6) Instead, they sought support from children, friends and community, while attempting to maintain the appearance of an intact relationship. Participants of these investigations were mostly Caucasian and middle class. Mouton et al. used data from the Women's Health Initiative study to estimate the prevalence of abuse in older women; they demonstrated that compared to Non-Hispanic White women, African American women over the age of 60 were less likely to experience verbal abuse alone but more likely to suffer physical abuse with or without concurrent verbal abuse.(8). None of these studies focused on older African American women alone.

In terms of EA in the African American community, formative work suggests there may be differences in the types of EA older African American women experience. Specifically, Griffin et al. found physical maltreatment of an elder to be unacceptable among African Americans, however resource sharing (financial, material) between extended family members was commonplace and acceptable.(9,10) The participants did not clarify whether such sharing was extensive enough to be considered abusive; nor was there any specific discussion of the forms of abuse and neglect experienced by older African American women in the family.

When it comes to seeking help for FV, while there is little data on EA help seeking, the IPV literature suggest that IPV survivors often list physicians as a valuable potential source of help.(11) Yet experiences with IPV interfere with the quality of the patient-physician relationship. In a focus group study of IPV survivors at community mental health centers, the majority of whom were African American, many participants stated that brochures and questionnaires at the center helped them disclose abuse.(12) On the other hand, in a sample of urban African American women seeking care in a community-based practice, women who had experienced IPV were less likely to report feeling cared for by the physician and more likely to report poor communication with their providers.(2) Zink et al. also have reported the results of qualitative investigation into the healthcare experiences of older IPV survivors.(13) The mostly middle class and Caucasian participants reported mixed experiences with healthcare providers. For half of the participants, disclosing IPV was a positive experience; as the physician helped them name the abuse, validated and supported them and help them understand its connection to their health. The rest felt that following IPV disclosure that the provider either did not know what to say, did not listen to them or dismissed them as a complainer. Finally, there are racial and ethnic differences in the way younger IPV survivors seek help, with younger African American survivors of IPV less likely than those who did not report IPV to seek help from authority figures (e.g. police), and more likely to report system barriers in accessing help for abuse.(14,15) However, studies have not examined how older African American women seek help for IPV, EA, or FV, and what role they expect physicians to play in getting them the help they may need.

It is necessary to pay attention to the issue of what constitutes FV among older African American women and where they seek help for the issues related to FV. With delays in marriage, higher rates of divorce and incarceration, and higher mortality compared to other ethnic groups, a high number of African American households are led by older women.(16) Such women often are considered to be the backbone of their community, especially in inner-city African American families, where older women often assume the responsibilities of parenting their grandchildren.(17) Unfortunately, these women are vulnerable to disease and adverse health outcomes, reporting poorer health status, more co-morbidities, than their Caucasian counterparts.(18,19) Since IPV and EA are both associated with poorer health outcomes, including higher rates of physical and mental health problems, older African American women who are FV survivors should be even more likely to seek medical care compared to non-abused women.(20–26)

Based on investigations in younger women, there is reason to believe that race, ethnicity and culture can influence how older women who are survivors of FV define and seek help for the same. For physicians and healthcare providers, understanding which actions and behaviors are considered abusive by older African American women is vital to be able to identify which patients have experienced abuse and neglect, which is the first step to assisting FV survivors within healthcare systems. While it is clear that certain acts, such as punching an older women is universally regarded as abusive, it is possible that the acceptability of resource sharing among African American communities might mean that older African American women may not consider sharing financial resources to be a form of FV, even when they share their resources at the expense of their own well-being. They may be more likely to report controlling, neglectful or verbally abusive behaviors as forms of FV, while physical abuse may be considered to be abhorrent.(9) With respect to help seeking behaviors, as a generation of women who is likely to have experienced racism, lack of trust in the system may amplify the barrier to communication between them and their physicians. Physicians need to know what abused older African American women think about their physician's role in assisting them, given the higher likelihood that these older adults may lack trust in healthcare systems.(27) Lack of trust also may have an impact on who they perceive as a source of help for FV; these women may report obstacles to seeking help that are different from older Caucasian women or younger African American women. To begin to fill in these gaps in knowledge, we undertook a qualitative inquiry of experiences of older African American women affected by FV. Attention was paid to perceptions of FV, help seeking behaviors, and barriers to securing resources.

2. Methods

2.1 Study design

This study was conducted as groundwork for a larger project to develop a culturally relevant, comprehensive scale to assess the presence and severity of FV among older African American women. For the purposes of this investigation, we defined FV as actual or threatened intentional actions of violence or control directed towards an older individual, by either an intimate partner or a family member in the home. We conducted a series of focus groups over a six month period (July 2005-December 2005).

2.2 Setting, recruitment, and participants

Our focus group participants were drawn from the ambulatory medicine clinics of a large, inner-city hospital in the southeastern United States that delivers care to the poor and indigent. Women over the age of 50, who self-identified as African American, and were at the clinic for a medical appointment, were eligible for the study.

2.3 Data collection procedures

We recruited potential participants from the clinic, through in-person recruitment, flyers posted on the wall, and after referral by clinic staff. No incentive was provided to the clinic personnel for referral. Study team members contacted eligible women to confirm interest and to schedule their group. We scheduled ten participants for each group anticipating a 60–70% show rate. The focus groups were held in a private room at the hospital, and were facilitated by one study team member (LMM), an African American clinical psychology fellow trained to conduct focus groups. We used the same focus group guide developed for the study for all groups. The open-ended focus group questions included questions regarding participant perceptions of FV, in general and specifically in the African American community; forms of FV experienced by older African American women; risk and protective factors for FV, and sources of and barriers to seeking help for the same. The guide also listed specific probe questions for each of the question categories listed above. Focus group discussions were audio-taped; audiotapes were transcribed by two study team members. The PI (AP) and one study team member (LMM) reviewed all transcripts for accuracy.

2.4 Data safety and confidentiality procedures

Due to the sensitive nature of the study, we had several safety procedures in place. The study was introduced as a study related to women's health, with further details described in the private room of the clinic. Written informed consent was obtained from all participants before the start of the focus groups according to the study's approval status through the university Institutional Review Board and hospital Research Oversight Committee. All participants were provided resources for obtaining help for FV and offered an opportunity to be talk to a team member (LMM) separately. All names were changed to ensure confidentiality in the focus group transcripts. Electronic copies of the transcripts were stored on a password protected computer accessible only to the study team.

2.5 Analyses

The transcripts were independently reviewed by the PI (AP) and one co-author (LMM). Code lists were generated by each reviewer, examined by the study team for content overlap, consolidated and then focus-group-guide question categories were added as codes. This master code list was reviewed to identify conceptually similar groups of codes; all transcripts were recoded by the PI using this master code list. Two authors (AP, AT) selected representative quotes to illustrate the themes that emerged from these interviews. ATLAS (Ti) software was used to track codes, code families and link quotations to themes. To ensure credibility, the following steps were implemented: independent coding of some data was conducted by more than one investigator, the two investigators actively involved in data collection (AP and LMM) were familiar with all interview transcripts; findings were triangulated with existing literature; and focus groups were conducted until theoretical saturation was achieved using a grounded theory approach.(28)

3. Results

Thirty women participated in 6 focus groups. All were African American with a mean age of 60.9 years (SD: 8.6 years). We did not collect data on FV status or income. We identified the following code families: (1) definitions of FV, (2) risk and protective factors and (3) help-seeking behaviors. This third category was subdivided into 'sources of help' and 'barriers or facilitators of help'.

3.1 Behaviors that constitute family violence

The participants in our study defined FV broadly, citing examples of physical, sexual, and emotional abuse; power and control; as well as neglect. Emotional abuse was thought to be one of the most commonly occurring forms of FV experienced by older African American women. Participants also identified several behaviors that they considered to be forms of emotional abuse. These behaviors included, not showing respect (by cursing or not being treated like a mother), isolating the older woman to control her or outright lack of attention towards material needs were most often cited. As an example, two participants stated:

“...taking all of her money and taking control of her and don’t want her to tell nobody so they keep her away from people.”

“Yeah, that’s (neglect) a form of abuse. And she was sick and they were talking about how many sores she had on her and all because not keeping her sanitary and clean, you know, bathing her.”

Often, emotional abuse occurred in the context of ongoing financial abuse, which also was thought to be commonplace.

“I just feel like I wasn’t treated like a mother. You know, like, well I’m your mom you know, why’d you take my money.”

“They will take completely over. They steal your check.... because my neighbor, he’s dead now, but his granddaughter she would go in his checkbook and go way over in the checks. She stole 3 checks from him and cleaned his account clean out.”

3.2 Sources of help for older African American survivors of family violence

Across all groups, participants perceived that help from God and from spiritual sources was more meaningful than help from any other source. In the words of one participant:

“Just take it to the Lord. Number 1. ‘Cause I tell you what, Lord sent me through a whole lot and got me out of a whole lot. That’s the best place you can go to get your answers and not worry about if it’s the truth.”

In addition to describing a personal connection with God, most participants, seemed to identify their religion an essential component of coping with the abuse, either through prayer or religious music.

“I turn on my church music so loud to try to block it out and go into another world. Sometimes that’s what you got to do. You got to learn how to meditate and take yourself away from that situation.”

Consistent with other studies of abused minority women,(14,15) institutions were not perceived to be accessible as a resource for abuse. While law enforcement officials were universally mentioned as inaccessible, physicians also were mentioned in this regard, based on participants’ personal experiences.

“Instead of them saying, I’m your doctor, I’m your friend, I’m here to help you.. ..they say, I’m gonna take care of your medical needs....[for] your personal needs you need to go to the legal aid somewhere.”

Despite these prior interactions, many participants expressed the desire to be able to seek help from their physicians. Indeed, one participant viewed the responsibility of physicians with

respect to FV in older women to be no different from their responsibility to assist abused children.

“I would love for the doctors to be with the older abused women like they are with the children...When the children come in and they see any little scratch on them they gonna call [Child Protective Services]. They need to be the same way about, for the older ones being abused.”

However, when asked about law enforcement officials, participants were unanimous in their belief that they (the police) were unhelpful. This participant's opinions represent those of most of the participants in her clear preferences of relying on religion over the police: “Believe it or not, I'd rather go to the Man in prayers than to go to the policemen.”

3.3 Barriers and facilitators to seeking help

Participants identified several barriers to accessing resources for FV. Of these barriers, lack of trust in the system and in people in positions of authority, including law enforcement authorities or physicians, were thought to be major hurdles to seeking and obtaining help.

“Black people as a whole find very little trust and confidence in government agencies. It goes back, way back. They think, if I go to them, they're not going to do anything or either they are going to tell me it's my fault and stuff like that.”

With respect to physicians, prior negative experiences with physicians, and poor communication between the doctor and the patient seemed to impact future patient physician interactions. For example, “They don't want you to tell them what's going on. They think they know your body. They don't want you to tell them. And they won't listen to you when you tell them what's going on.”

A few system-wide barriers were identified as possible hindrances for older abused African American women getting help. They believed that there were few resources for abused older women, including support groups

“Because the system is not equipped as it should be. They don't have a lot of resources for you to go to now because a lot of things have been closed down.” “They need a strong support group to back them up and someone that will give them the moral support that they need.”

Finally, participants identified individual-level barriers to receiving services for FV, including isolation (circumstantial or deliberate); denial of abuse; fear of being judged; fear of repercussions; and lack of tools to get help; including knowing whom to ask, where to go and having the finances to do so. Again, the participants drew a parallel between abuse of older women and maltreatment of children.

“Mainly that's what it is, they don't tell it because like children when children be abused they won't tell it because they scared to tell it. Older people the same way. They afraid to tell it because they're afraid ain't nobody go listen at them.”

4. Discussion and conclusion

4.1 Discussion

Our qualitative investigation into the attitudes and perceptions of FV in older African American women provides initial empirical understanding of how these individuals perceive and are affected by violence in the home. Our study also adds to the growing body of knowledge on abuse in older adults, especially as it relates to older women trying to talk about the violence

with their physicians and whom they perceive to be particularly helpful when it comes to seeking aid for their FV. Like those of Griffin et al.,(9,10) our findings suggest that emotional abuse and financial abuse are commonplace. Thus, even though resource sharing may be considered acceptable by some members of this community, these women were very clear that “borrowing” money or “taking one’s check” is abusive. While we did not collect financial data from our participants, the women who shared their perspectives with us were drawn from a clinical site where a majority of women over 50 are socio-economically disadvantaged.(29) Therefore, financial abuse in this community is not just a matter of losing one’s assets,(30) as may be the case in other communities. Indeed, it has the potential to affect the health of the survivor, because they may not be able to afford their medications or co-payment for their healthcare appointments.

Participants in our study also shared their thoughts about sources of help for the FV they endured. In particular, their faith and trust in God seemed to stand out as one of the vital avenues for assistance for abuse and neglect. This finding is concordant with the trust in God expressed by participants in a study of African American patients receiving care at the end of their life at this clinical site(31) and is in keeping with the central role that religiosity and spiritual belief plays in lives of the African American community.(32) Increasing attention has been paid to the use of faith as a coping strategy for recovery from substance abuse and mental health problems as well in younger survivors of IPV(33). The data gleaned from this project suggest that the same may be true for older African American women living with or recovering from FV.

The lack of trust in police and law enforcement officials voiced by our participants also was striking. While this is consistent with prior qualitative work among younger African American women,(15) data from the National Crime Victimization Survey(34)and from a cross-sectional study of 419 abused women in the Southern United States(35) indicate that African American women are quicker to call the police to report abuse when compared to Caucasian women. However, the issue of past experiences with racism was not addressed in these papers. Based on our findings, we hypothesize that among older African American women, the lack of trust in the system as well as perceived racism will influence the extent to which these women will call the police for incidents of abuse.

With respect to the role that physicians play, older African American women do not seem to differ from their younger counterparts; while they do expect physicians to be able to help, they experience barriers to communicating their concerns with their doctors. Healthcare providers need to be aware of these beliefs, just like they need to be cognizant that the forms of abuse and neglect older African American women experience (emotional and financial) may be not be obvious during the visit.

Finally, the individual barriers to receiving services seem to be no different among older African American women compared to younger African American women. However, issues related to the length of the relationship, including worries related to their abusive partner’s ill-health, did not seem to be a concern at all. It is possible that our participants may not have been abused by a long-term partner, or were more likely to have had experiences with abuse and neglect by family members other than partners.

Study results should be considered in light of the following limitations. Use of focus groups instead of individual interviews may have caused some participants to feel reluctant about expressing their opinions to the group. This choice could have altered the codes generated. In addition, as the PI was involved in the clinical care of these participants, we had only one facilitator and lacked the ability to accurately record nonverbal group interactions. Even though we triangulated our findings by having two team members read and develop code lists and

having a third team member review these codes, we did not invite focus group participants back to comment on the themes identified by the study team members.

4.2 Conclusion

Given the hypotheses raised by our analyses, we now have the groundwork to be able to further define the extent of the problem of FV among older African American women. Our focus group participants provided a unique insight into the perceptions of FV in a group that has received little attention until now and therefore may be overlooked when it comes to identification and provision of services for the same within healthcare settings. Physicians who care for older African American women may be able to use this information to help them understand the implications of FV, especially financial abuse, for the health and wellbeing of women who face a dual risk to their health, on the basis of their race and their FV experiences.

4.3 Practice implications

The results have several implications for physicians. First, physicians need to be aware that mere identification of FV may be insufficient. Older African American women also expect physicians to act as an advocate and resource for them. Second, as prior negative experiences may impair physician-patient communication, healthcare providers need to attend to subtle cues that patients may offer regarding ongoing or intermittent FV, and initiate a discussion about the possible ongoing violence at home. Finally, physicians caring for older African American survivors of FV need to be attuned to the salient role that spiritual beliefs may play in their recovery from FV. Not all physicians feel comfortable discussing spirituality with their patients during the office encounter, especially if their personal view is discordant with their patients' beliefs. Even though the extent to which spirituality should be discussed in the clinical encounter is still a matter of debate,⁽³⁶⁾ at least one large cross-sectional study suggests that many patients find a spiritual conversation appropriate especially in the context of abuse.⁽³⁷⁾ Given our participants' views, healthcare providers should consider the central role that spirituality plays in coping with abuse when making referrals to resources for their older African American patients providing referrals to pastoral care, if available and appropriate.

Acknowledgements

Funding for this study was made possible through a grant awarded to Dr. Paranjape through the Emory Mentored Clinical Research Scholar's program. Dr. Paranjape's time was supported in part grants from the NIH/NCRR (K12 RR017643 and K23 RR023364).

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