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Disclosure Among Victims of Elder Abuse in Healthcare Settings: A Missing Piece in the Overall Effort Toward Detection

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Abstract

Elder abuse remains a largely hidden problem in our society and only a small minority of victims are connected to formal support/protective services. Healthcare settings have been identified as a critical milieu to uncover cases of elder abuse; however, under-detection in these settings is a major issue. Victimization disclosure is an important component within the overall detection effort, yet it has received little attention in the elder abuse literature. Drawing on relevant literature from other domains of family/interpersonal violence, this article highlights the disclosure process, as well as disclosure barriers, facilitators, and competencies to consider when working with older adults.

Keywords

Elder Abuse; Disclosure; Healthcare; Review

INTRODUCTION

Elder abuse (EA) is recognized as a serious public health concern associated with major consequences, including pre-mature mortality, physical and mental health morbidities, and increased healthcare services utilization (Dong, 2015). EA refers to intentional acts or lack of action by a person in a relationship with an expectation of trust that causes harm or risk of harm to an older adult; it is comprised of five subtypes, including financial exploitation, emotional/psychological abuse, physical abuse, sexual abuse, and neglect, which often occur concurrently (Centers for Disease Control and Prevention, 2016). Approximately 10% of older adults, aged 60 years or above, living in the community experience some form of EA each year (Acierno et al., 2010; Pillemer, Burnes, Riffin, & Lachs, 2016).

EA remains a largely hidden problem with only 15% of victims connecting with formal support services each year (Burnes, Acierno, & Hernandez-Tejada, 2018). Healthcare settings, such as primary care clinics or emergency departments, have been targeted as

critical points of EA detection (Beach, Carpenter, Rosen, Sharps, & Gelles, 2016; Platts-Mills et al., 2018). A disproportionate number of EA victims interface with the healthcare system (Dong, 2015) and such visits may represent the only opportunity for detection among EA victims who are often socially isolated (Acierno, Hernandez-Tejada, Anetzberger, Loew, & Muzzy, 2017). EA victims may also present to healthcare settings due to injury or chronic illness precipitated by abuse/neglect. Although healthcare practitioners are often unaware of their patients' abuse experiences, victims of interpersonal violence may associate healthcare services with safety and feel more comfortable disclosing in these settings (Spangaro, Zwi, Poulos, & Man, 2010). Despite efforts to increase EA detection in healthcare settings, such as the development of clinical screening instruments and hospital-based multidisciplinary teams (Rosen et al., 2018; Rosen, Hargarten, Flomenbaum, & Platts-Mills, 2016), under-detection remains a major issue (Evans, Hunold, Rosen, & Platt-Mills, 2017). The process of victim disclosure receives very little attention in the EA literature yet represents an important component of overall efforts to detect cases and connect victims with protective/supportive services. Drawing on relevant literature related to adult abuse survivors and domestic violence/intimate partner violence (DV/IPV), this paper seeks to highlight key considerations toward facilitating increased EA disclosure among older adult victims who interface with healthcare providers.

WHAT IS DISCLOSURE?

The National Institute for Health and Care Excellence (2014) defines disclosure as when “an adult or child who has experienced or perpetrated domestic violence or abuse informs a health or social care worker or any other third party” (p.41). Disclosure is generally conceptualized as a dynamic process that evolves over time rather than a discrete or single outcome event (Alaggia, 2004; Alaggia, Regehr, & Jenney, 2011). Montalvo-Liendo, Wardell, Engebretson, and Reininger (2009) describe the disclosure process among victims of DV/IPV as: a) keeping the abuse behind closed doors, b) lying/denying, c) making a disclosure under crisis circumstances to unburden the weight of abuse or receive validation, and d) retraction of disclosure. Similarly, disclosure among children/adolescents is characterized by a non-linear process involving stages of denial, reluctance, delayed, tentative or active disclosures, recantation, and re-affirmation (Sorensen & Snow, 1991). As victims progress through the disclosure process, they may test the viability of a potential receiver/listener by gauging boundaries, seeking tacit permission, or providing information incrementally (Petronio, Flores, & Hecht, 1997). The disclosure process can take months or years to unfold and most victims are in a state of denial or tentative disclosure, rather than a state of active disclosure (Sorensen & Snow, 1991). Given the complex dynamics surrounding most EA cases, it is expected that EA victimization disclosure follows a dynamic process as well, which may not be adequately facilitated using existing screening tools that are administered as brief, discrete events.

EA victim disclosure is expected to correspond with an increased likelihood of being connected with formal support interventions designed to improve safety and well-being (Burnes, Breckman, Henderson, Lachs, & Pillemer, 2018). The process of disclosing maltreatment itself may also contain implicit therapeutic benefit, depending on the

clinician's response, and contribute to future help-seeking behavior (Breckman & Adelman, 1988).

BARRIERS TO DISCLOSURE

The DV/IPV literature has identified several barriers to disclosure relevant to the EA experience. Clinicians must be aware that victims often experience internal barriers to disclosure such as shame, stigma, self-blame, and embarrassment, as well as fears related to perpetrator retaliation and escalation of abuse (Alaggia, Regehr, & Rishchynski, 2009). There may also be cultural barriers related to collectivism, social harmony, and family honor, and if compromised, communities can respond with shunning and ostracization (Burman & Chantler, 2005; Yan, 2014). Particularly relevant to older adults living with psychosocial and/or health-related vulnerabilities, victims may be reluctant to disclose their abuse out of concern of losing limited financial or social supports or that disclosure could impact critical relationships with caregivers upon whom they depend for daily needs. Many older adults are reluctant to report mistreatment out of fear that it could lead to placement in a long-term care or nursing home facility. Typically embedded within complex family dynamics, EA victims may also be concerned that disclosure could result in severing the relationship with their familial perpetrator or implicating the perpetrator in the legal/justice system (Burnes, 2017). Indeed, the DV/IPV literature suggests that victims are hesitant to disclose out of concern that it will set off a chain reaction of life events over which they have little control (Alaggia et al., 2011). A clinician's insistence that a victim leave the perpetrator or pursue other major life-altering actions can be a serious deterrent in the disclosure process (Keeling & Wormer, 2011).

WHAT CAN PRACTITIONERS DO TO SUPPORT DISCLOSURE IN HEALTHCARE SETTINGS?

Disclosing victimization is hindered when patients perceive their healthcare provider as lacking time or interest, demonstrating discomfort, or failing to provide an explanation for abuse-related questions (Spangaro et al., 2016). Rhodes et al. (2007) suggest that the potential for disclosure increases when providers demonstrate responsiveness to psychosocial matters, since it indicates concern for non-medical issues. Perceived trust is important in eliciting disclosure and can be developed when clinicians listen carefully, show genuine interest, and take time to address patients' concerns (Battaglia, Finley, & Liebschutz, 2003). Disclosure is facilitated when the perceived attitude of the clinician includes demonstrations of respect, compassion, and non-judgment (Alaggia et al., 2011; Spangaro et al., 2016). Emphasizing confidentiality and offering conditions conducive to privacy, particularly away from the suspected perpetrator, can promote disclosure (Montalvo-Liendo et al., 2009). One-on-one privacy is germane to practice with older adults, who commonly attend appointments with their caregiver or other family members. On the other hand, some victims of elder abuse have key informal supporters in their lives helping them manage the mistreatment situation (Breckman et al., 2018), and the presence of such supporters may facilitate help-seeking behaviors such as disclosure (Burnes, Breckman, Henderson, Lachs, & Pillemer, 2018).

Victims are attuned to clinicians' hesitance in discussing victimization. Direct asking about potential victimization is important because it indicates a readiness to hear disclosures (Spangaro et al., 2016). Clinicians can begin with innocuous, open-ended questions such as "how is it going with [family member] helping you out at home" or "how have things been going since [child/grandchild] has moved back into the home", which provide opportunities for discussion before steadily progressing to more focused, probative questions (e.g., how are disagreements or conflict handled in your family? what is conflict like for you at home?) (Alaggia et al., 2009; Rhodes et al., 2007). By introducing the topic, explaining the purpose of questions, and offering choice in answering, clinicians share control and challenge the traditional power dynamics of healthcare settings (Battaglia et al., 2003; Spangaro et al., 2016). As outlined above, practitioners must recognize that disclosure is a process that may unfold over the course of several visits, and they should remain open, patient, and continue to ask questions (Montalvo-Liendo et al., 2009). Older adults, in particular, under-report personal issues such as abuse and neglect (Acierno, 2003). Clinicians should integrate information about clinical EA presentation/symptomology and factors that place older adults at higher risk for EA to help decide when direct asking should be initiated or pursued (Cohen, Levin, Gaglin, & Friedman, 2007).

HOW SHOULD PRACTITIONERS RESPOND TO VICTIMS OF MISTREATMENT?

A major barrier to disclosure among victims is the fear of receiving a negative or stigmatizing reaction. Indeed, a negative reaction to victim disclosure can contribute to serious consequences for a victim such as symptoms of depression or post-traumatic stress disorder, maladaptive coping, self-blame, low-self-esteem, as well as disclosure retraction and foregoing medical care, which can contribute to further isolation (Liebschutz, Battaglia, Finley, & Averbuch, 2008). Thus, within the interpersonal dynamic of the disclosure process between a victim and healthcare provider, the receiver's reaction is critically important.

Negative or stigmatizing reactions are characterized by attributes of blaming or minimizing the abusive experience. DV/IPV victims commonly express concern that practitioners will respond with disbelief or judgment for either being in an abusive relationship or failing to protect themselves (Narula, Agarwal, & McCarthy, 2012). A common negative response is abruptly switching topics or rushing through the conversation, which can result in victims feeling ignored or dismissed (Rhodes et al., 2007). Some practitioners suppress disclosure by sharing their own negative views of the act (Alaggia et al., 2011).

On the other hand, disclosure can be life-changing if clinicians provide validation, empathy, support, encouragement, and suggestions rather than demands (Rhodes et al., 2007). Disclosure is often motivated by a desire for someone to listen without being told what actions to take (Montalvo-Liendo et al., 2009). Practitioners must be aware of ageist interpersonal tendencies to patronize or paternalize older adults, which may exacerbate the potential to direct action, rather than listen. By validating and assuring patients that the perpetrator's behavior is indeed abusive and that no one deserves to be abused, self-worth can be restored thereby empowering victims to make changes (Liebschutz et al., 2008).

Explicit acknowledgement of the disclosure and provision of referrals and follow-up have also been well-received by victims (Narula et al., 2012).

WHAT CAN BE DONE FROM AN INSTITUTIONAL PERSPECTIVE?

Institutional or environmental factors may also influence the likelihood of EA victimization disclosure. Indeed, healthcare settings can unintentionally contribute to distress and/or re-traumatization, which could hinder disclosure (Ghandour, Campbell, and Lloyd, 2015). A trauma-informed care (TIC) orientation provides insight into ways that EA victimization disclosure can be facilitated/supported at an institutional level (Ernst & Maschi, 2018). The TIC aim is to reduce re-traumatization and support recovery, which often begins with the process of disclosure (Elliot, Bjelajac, Fallot, Markoff, & Reed, 2005). Core TIC values include empowerment, connection, collaboration, choice and control, safety, and trustworthiness and should be reflected in an organization's relationships, interactions, and environment (Harris & Fallot, 2001). TIC suggests that clinicians share power and maximize choice.

Adopting a TIC framework for practice requires a cultural shift in organizations (Harris and Fallot, 2001). To this end, several recommendations emerge from the TIC orientation to help facilitate EA victimization disclosure from an institutional perspective. Victims can be involved in the design, evaluation, and delivery of services to help integrate sensitive practices. All institutional personnel, including service providers, administrators, and board members should receive training about EA and the impact of victimization on an older adult's health (Elliot et al., 2005; Ernst & Maschi, 2018). Training is essential among physicians who commonly describe a reluctance of asking about abuse victimization for fear of opening "Pandora's box" (Sugg & Inui, 1992). Trainings involving role play and mnemonics have been shown to improve communication skills, including open discussion and direct asking about victimization (Edwardsen, Morse, & Frankel, 2006). The DV/IPV literature has also noted a need to provide clinicians with specific organizational protocols in responding to abuse (Bates, Hancock, & Peterkin, 2001). In regard to physical environment, healthcare settings ought to have smaller, private spaces available where victims can feel safe in disclosing without being overheard (Bates et al., 2001). Visible forms of support, such as the distribution of EA brochures and information cards or placement of posters and flyers in common areas may facilitate disclosure by illustrating the institution's commitment to and familiarity with abuse victimization. According to Bates et al. (2001), victims are relieved and comforted by the presence of posters and signage as it helps them come to terms with their own situation.

FUTURE DIRECTIONS

Further research is required to understand elements that are unique to the disclosure process for EA victims. Compared to DV/IPV, EA scenarios involve a different array of potential perpetrators, such as child or grandchild offspring. EA scenarios also often involve victims with physical/cognitive vulnerabilities and dependency upon the perpetrator for daily care needs. EA can be characterized by long-term DV/IPV patterns that continue into older adulthood or scenarios that arise for the first time in older adult due to age-associated

vulnerabilities (National Research Council, 2003). EA also includes additional forms of mistreatment compared to DV/IPV, including financial abuse and neglect. Thus, the victim-perpetrator relationship dynamics and the nature of mistreatment characterizing EA diverges from DV/IPV scenarios, which could influence both the process of disclosure and the clinical techniques required to facilitate it. It is unclear how to facilitate disclosure among older adults who lack capacity. Among patients with cognitive impairment, evidence suggests that caregivers are willing to disclose EA (Fang & Yan, 2017; Ho, Wong, Chiu, & Ho, 2017) and, thus, disclosure techniques targeted toward caregivers may need to be developed. Alternatively, disclosure techniques that facilitate disclosure among older adults who lack capacity may be possible given evidence that older adults with mild to moderate cognitive impairments are able to recall and describe abusive events (Wiglesworth et al., 2009). In such cases, supported decision-making is an option that recognizes the personhood of victims with cognitive impairments and allows them to continue as the primary decision-maker with assistance from their support network (Diller, 2016).

Disclosure represents a critical piece of the overall effort to detect EA victims who remain overwhelmingly hidden in our society, yet it has received little attention in the EA literature. Clinicians who work with older adults in healthcare settings are likely to interact with EA victims on a routine, everyday basis (Pillemer et al., 2016). This paper highlights the disclosure process, barriers and facilitators, as well as practice competencies, to consider when working with older adults.

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