A Case Series of Intimate Partner Violence in Older Adults Within an Older Persons' Mental Health Service

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Abstract

Purpose: The aim of this case series is to explore the range of considerations (ethical, practical, and legal) for mental health clinical assessment and management of older adults experiencing intimate partner violence (IPV).

Case Series: Three case reports are described. Participants were older adults presenting to an Older Persons Mental Health service in a metropolitan area who reported experiencing recent IPV (either as a survivor or perpetrator). Each case illustrates aspects of the complex issues to be considered in the assessment and management of IPV in older adults, including clinical factors (eg, cognition, interpersonal relationships, mental illness), ethical dilemmas, and legal, sociocultural, and practical considerations.

Conclusion: This case series highlights the complexity in assessing and managing IPV in both members of the older adult dyad within a mental health service. Specific approaches to IPV are required given the physical, emotional, and cognitive interdependency often present in older adults.

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Domestic violence (DV) is associated with physical and mental illness across the lifespan.[1] Intimate partner violence (IPV) is a form of DV defined as "behavior by an intimate partner or ex-partner that causes physical, sexual, or psychological harm, including physical aggression, sexual coercion, psychological abuse, and controlling behaviors."[2] Coercive control is a form of abuse that deprives a person of their independence and freedom.[3] In older adults, IPV is poorly identified, with a limited understanding of its impact, treatment, and referral options. Most research refers to "elder abuse," referring to all forms of abuse (including neglect) towards an older person without reference to the perpetrator. IPV is not differentiated within elder abuse,[4] contributing to under-recognition.[5] Prevalence rates vary from 27% in older women for any abusive behavior within an intimate relationship,[6] to lifetime prevalence of 16.5%–54.5% in women ≥45 years.[7] Data regarding IPV in older men[8] and from diverse communities are scarce. A study of transgender adults aged 50+ years found a 57% lifetime prevalence of IPV.[9] There are limited studies on the frequency and impact of dementia on IPV.[5]

The assessment and management of IPV in older adults requires a coordinated approach. The specific circumstances of older people experiencing IPV, including frailty, caring responsibilities, and physical and mental health, should be considered alongside personal values, risk assessment, and safety planning. Knowledge of available community supports and addressing barriers to recovery are important.[10] Clinicians have an opportunity, and arguably a duty,[11] to recognize and respond to older people experiencing IPV within mental health settings,[12] especially given the higher risk of death from violent acts compared to younger people.[13]

The aim of this case series is to explore the breadth of issues clinicians may consider in the assessment and management of different presentations of IPV in older adults referred to mental health services. Awareness of the complex and interrelated medical, physical, relational, sociocultural, and legal factors pertinent to IPV may improve clinical practice in this field.

Editor's Note

We encourage authors to submit papers for consideration as a part of our Focus on Geriatric Psychiatry section. Please contact Jordan F. Karp, MD, at psychiatrist.com/contact/karp, or Gary W. Small, MD, at psychiatrist.com/contact/small.

Clinical Points

- The literature often places intimate partner violence (IPV) with older adults under the umbrella of elder abuse, obscuring the distinct needs in this population. This case series highlights the need for specific attention to the complexities of IPV presentations within mental health services.
- Later life presentations with IPV require assessment and management of both members of the dyad. Physical, emotional, and cognitive interdependency necessitates the development of specific responses and solutions for this age group.
- A holistic approach integrates assessment of mental health, cognition, relationship, and sociocultural dynamics, and safety risks, with connections to matched legal and community resources and mental health services.

METHODS

Case Selection and Setting

Participants were patients of an Older Persons Mental Health (OPMH) service in Sydney, Australia, who reported experiencing recent IPV (either as a survivor or perpetrator).

Data Collection

Deidentified participant data were collated from medical records. Names have been replaced with pseudonyms.

The study was approved by the Concord Hospital Human Research Ethics Committee (CH62/6/2022-177). Written informed consent was obtained from all participants.

RESULTS

Case 1

George* was a 77-year-old man living with his wife, Sarah, in their own home. He was referred to the OPMH unit with an 18-month history of delusional jealousy, accusing Sarah of having affairs. He became increasingly controlling and irritable around her, hired a private detective to follow her, and used recording devices. He had confronted a stranger about having an affair with Sarah and had obstructed her leaving a room. There was no prior history of IPV.

George was independent in personal and instrumental activities of daily living (ADLs). Subjective decline in short-term memory was reported, although bedside cognitive testing was normal, and there was no functional impairment. There was no psychiatric history. He had hypertension. Late-onset delusional disorder (jealous type) was diagnosed.

George required involuntary treatment of mental illness under the Mental Health Act 2007 (New South Wales) due to impaired insight, medication nonadherence, and risks to others. His wife and children were actively involved in the risk assessment (providing collateral history about violent episodes, triggers, and outcomes) and received psychoeducation, and counseling about IPV. George was managed by a multidisciplinary team (MDT). He initially received oral risperidone to establish tolerance and monitor for emergent side effects, before transitioning to depot formulation (25 mg intramuscularly fortnightly), as was his preference, and to improve adherence. Consequently, his delusions of jealousy and irritability attenuated, with infrequent concerns about infidelity. A specialist forensic assessment examined George's risk and protective factors for violence and spousal assault, and protective factors. A Domestic Violence Safety Action Tool (DVSAT[14]; available at https://sydneynorthhealthnetwork.org.au/wp-content/uploads/2022/09/Domestic-Violence-Safety-Assessment-Tool.pdf) assessed threat levels in conjunction with a clinical assessment.

A safety plan for Sarah was developed with George's family. The social worker informed the family about legal avenues to protect Sarah, including Apprehended Violence Orders,[15] women's legal services, and Legal Aid's[16] DV unit (Table 1). The family received counseling from the clinical psychologist and accessed external carer advocacy and IPV counseling services. Discharge planning was complicated by Sarah's financial dependence on George. As such, she preferred that he return to the family home, despite being afraid of him. George had an Aged Care Assessment Team[17] † assessment and agreed to respite placement in a residential aged care facility (RACF). This provided a safe, supported environment for George to receive step-down care alongside ongoing mental health treatment and addressed Sarah's safety.

George received ongoing treatment from the OPMH team through a Community Treatment Order (CTO; Table 1),[18] given concerns about minimization of symptoms and nonadherence due to limited insight. Involuntary treatment was considered carefully, weighing up George's right to autonomy with the risk of further harm to Sarah (eg, stalking and aggression). The 6-month CTO compelled George to accept treatment, which reduced the intensity of his delusions and thereby the risk of harm to Sarah. The CTO mandated community

*Names used in case reports are pseudonyms.

†The Aged Care Assessment Team is a specialist multidisciplinary team that assesses older adults to ascertain their functional abilities/limitations, care needs, and eligibility for government funding for aged care support services.

Table 1.
Legal Entities Relevant to IPV in New South Wales, Australia

Legal entity	Description
Apprehended Violence Order (AVO)	AVOs restrict individuals from "engaging in certain behaviors" as laid out in the Crimes Act 2007 (NSW). It is the term used in New South Wales, Australia. Laws relating to these orders differ in name and scope between States and Territories in Australia.
Community Treatment Order (CTO)	CTOs are legal orders made by a Mental Health Review Tribunal or a Magistrate that mandate care (which may include medication or therapy) for a person with mental illness in the community. The name and scope of CTOs vary between States and Territories in Australia.
Mental Health Act 2007 (New South Wales)	The main purpose of the Mental Health Act, which varies by jurisdiction in Australia, is to ensure the care and treatment of people who are mentally ill or mentally disordered, as per the specific definitions under the Act. To be found mentally ill under the Mental Health Act 2007 (NSW), a person must have a condition that impairs their mental function as shown by particular symptoms, be at risk of harming themselves or others, or have a continuing condition (where deterioration in mental state with associated harm is likely without treatment).
Guardianship Act 1987 (New South Wales)	The Guardianship Act, which varies by jurisdiction in Australia, relates to the guardianship of persons with disabilities. The Guardianship Act (NSW) governs the appointment of guardians for adults with impaired decision-making due to a disability, which may include cognitive impairment and physical or mental illness. A guardian can make decisions affecting the disabled person's accommodation, support services, health, and general lifestyle matters under guardianship orders.
Legal Aid	Legal Aid is an independent government agency that provides publicly funded (ie, free) legal advice and representation.

Abbreviation: IPV = intimate partner violence.

OPMH reviews, providing regular monitoring of his mental state and medication side effects. George's rights were further safeguarded by scheduled review by the Mental Health Review Tribunal, who could extend or revoke the CTO according to contextual factors (eg, patient no longer mentally ill or voluntary engagement in treatment).

Case 2

Ray was a 73-year-old man living alone who was admitted involuntarily following a high-lethality suicide attempt that occurred during a relapse of depression in bipolar disorder. He had narcissistic personality traits. Prior to his presentation, Ray was poorly adherent to sodium valproate and community OPMH care. Although IPV was not initially identified as a presenting problem, Ray described wanting to punish his ex-wife, Tina, following their separation 6 months prior. He described shame losing his role as patriarch and having to live alone. This fostered feelings of guilt in Tina and their children, who felt obliged to communicate with and support Ray.

The family elaborated a history of IPV dating back several years in the 40-year marriage. The nature and intensity of this changed over time, characterized by coercive control (verbal abuse and controlling behavior) with more recent threats to harm himself if not allowed to return home being another example of coercive control. Prior to admission, Ray had unsuccessfully attempted to drive into oncoming traffic, with intent to threaten Tina, his passenger.

Following initial medical treatment in intensive care, Ray was transferred to the OPMH ward. He responded well to sodium valproate (titrated to 750 mg twice daily) and cognitive behavioral therapy targeting symptoms of hyperarousal and anxiety. Ray was cognitively impaired, scoring 21/30 on a Montreal Cognitive Assessment.[19] Formal neuropsychology assessment confirmed mild neurocognitive disorder. An occupational therapist's functional assessment noted prior independence in ADLs apart from shopping due to mobility issues.

Once his depressive symptoms improved, Ray had a forensic psychiatry assessment. His case was escalated to a Safety Action Meeting (SAM) (an Australian statewide multiagency service) that helped develop a safety plan, support his ex-wife and family, and link them with the police DV unit.[20] The SAM comprises various government (eg, health, police, community services) and nongovernment agencies and may include specialist IPV support teams, case managers, counselors, and accommodation services who can share information to elaborate a survivor's situation and collaborate on a safety action plan. The social worker regularly contacted Tina to ascertain risks and provide support regarding the IPV.

In discharge planning, the inpatient team sought to mitigate modifiable risks—optimizing medication-based management of his mood, limiting access to means of overdose, improving his family's knowledge and management of risks and safety planning, and providing referral for psychological support. Ray ultimately agreed to live in a RACF, accepting forensic recommendations that it would be unsafe for him and Tina to cohabit. He was discharged with assertive case management from OPMH under a 6-month CTO.

Case 3

Agatha is a 76-year-old woman of Mediterranean origin admitted with a relapse of psychotic depression. She had no functional or cognitive impairment. Agatha lived with her husband Leo. Agatha disclosed long-

standing IPV perpetrated by Leo since age 27. Her depressive symptoms were exacerbated by Leo's threatening gestures and verbal aggression. Since developing dementia, Leo had become increasingly dependent on Agatha. He had previously required inpatient management of depressive symptoms, including apathy, irritability, and suicidality. His mental illness, cognitive disorder, and greater dependency on her exacerbated Agatha's symptoms. However, she felt a cultural expectation and sense of duty to care for Leo despite his violence. She worried his depressive symptoms would recur in her absence or that he might self-harm.

Agatha's symptoms improved with venlafaxine 150 mg and olanzapine 5 mg mornings and 10 mg nightly, targeting depression and psychotic features, with a plan to slowly wean olanzapine after resolution of psychosis. Agatha did not want to separate from Leo or pursue legal avenues to manage the IPV. After discharge, a safety assessment was conducted assessing immediate personal and environmental risks, health and cognitive factors, safety plans, and support. Agatha understood the risks and was informed of strategies to manage IPV including having crisis-line numbers. The case manager empowered her to become financially independent by opening her own bank account. She was connected to IPV counseling services and received psychoeducation about dementia and managing Leo's changed behaviors, recognizing early warning signs of aggression. Leo was referred to OPMH for assessment and management and referred to a culturally specific support worker to facilitate social contact. This enabled Agatha respite from Leo and time to attend counseling and social activities. OPMH follow-up continued for several months until resolution of Agatha's depression.

DISCUSSION

Assessment

The cases demonstrate how IPV may present in older adults and the breadth of issues to be considered in mental health assessments. These presentations highlight the challenges of identification of IPV given the infrequent nature of the presentations. IPV may be a contributing factor or consequence of mental illness. A comprehensive assessment of older adults affected by IPV (as perpetrators or survivors) requires a sensitive and holistic approach.

Assessment involves evaluating mental illness, cognition, interpersonal relationships, personality factors, physical health issues/frailty, substance use or dependence, previous/current violence, finances, accommodation, and cultural considerations. Clinicians must also have knowledge of the law and resources. Specialist mental health services are skilled in assessing mental illness but may less routinely evaluate cognition.[21] Brief screening tools like the Montreal Cognitive Assessment[19] or the Rowland Universal Dementia Assessment Scale for culturally and linguistically diverse people or those with limited educational attainment[22] may be used, with referral to neuropsychology for more detailed testing. Use of professional interpreters where needed is recommended,[23] and culturally specific assessment may be valuable (Table 2). Assessing these factors requires a MDT, cultural considerations, and multiagency approach[12] (see Table 2 for specific roles). In Ray's case, a forensic assessment helped determine risk-mitigation strategies such as the recommendation not to cohabit. The communication of this information with the SAM combined with cognitive assessment established that he required supported accommodation (a RACF). This case highlights the utility of interdisciplinary expertise to enhance clinical formulation and inform personalized management. The risk factors, comorbidities of both members of the couple, and management are informed by age-related factors, gender dynamics, and the development of neurocognitive impairment, highlighting the utility of dual-trained psychiatrists in old age and forensics.

All cases discussed involved male perpetrators of IPV, as is the most common dynamic.[8] The prevalence of IPV perpetration by gender in older people is not well understood for various reasons, including different definitions of "older," older adults not conceptualizing certain behaviors as abuse, few data on older male-identifying victims, and a focus on female victims.[8,24] A US survey of IPV over a 12-month period found that males aged ≥60 years had significantly greater odds of interpersonal physical violence compared to older females, and there were no significant sex differences for psychological aggression and sexual violence.[25] Older men may be more likely to report being the victim of physical violence compared to women,[25,26] perhaps due to a shift in power-control dynamics with aging and greater dependency in these older men. Alternatively, men may be more comfortable revealing abuse in later age or older women more likely to perpetrate violence.[27] More studies are needed to examine the prevalence of older male victims of violence and qualitative work to understand issues in this group.

Evaluation of risk and protective factors is an important part of assessment and may be informed by state or national risk assessment principles.[28] Risk assessment may be aided by adapting tools such as the DVSAT,[14] an Australian state-specific tool that combines risk identification processes with professional judgment. Where cognitive impairment is involved, knowledge of assessment and management of changed behaviors can help determine risks and potential modifying factors.[29]

As seen in the illustrative cases, a collateral history from spouses and/or family was essential. The

Table 2.
Roles of the Multidisciplinary Team in Assessment and Management of IPV

Clinician	Role
Doctor	Assessment, formulation, and management of physical, cognitive, and psychological issues, including the impact of violence; identify risk and protective factors; recommend interventions, such as initiating appropriate pharmacotherapy and referrals; advocacy for and liaison with patients and families around care planning.
Social worker	Provision of educational resources and guidance to partners or families, safety planning, financial support, aged care packages and activities of daily living support, navigating legal pathways, and accommodation changes.
Occupational therapist	Cognitive and functional assessments to inform overall assessment and identify supports needed and safety planning.
Clinical psychologist	Psychological assessments, provision of tailored psychological therapies, and coping strategies including to families/partners.
Neuropsychologist	To assess the domains and degree of cognitive impairment and relative strengths, which guide treatment plans and management of intimate partner violence.
Nurses	Providing comprehensive assessment, assistance with activities of daily living, clinical monitoring, and close support to patients and families (depending on setting of care).
Forensic specialists	Providing a comprehensive assessment that considers risks, to inform treatment, safety planning, and legal aspects of care.
Transcultural mental health center	A statewide service in New South Wales that works with culturally and linguistically diverse communities, partner organizations, and health professionals to support mental health. Their services include culturally specific clinical assessment and referral processes, education, mental health promotion, early intervention, and service development.

Abbreviation: IPV = intimate partner violence.

identification of abuses using a model such as the Duluth Power and Control Wheel, a visual depiction of tactics and patterns of abuse types,[20] could help build an overall picture of the relationship dynamic and double as an educational tool, given that older adults may not recognize themselves as survivors of violence. For example, the derived graphic could help an older adult appreciate the different forms of coercive control, such as withholding care, financial exploitation, threatening institutionalization, or dismissing concerns by attributing them to cognitive decline. Gathering this information requires sensitivity, care,[10] and nuanced interpretation, noting there may be feelings of stigma and shame[6] and viewed within the lens of relational autonomy and safety.[30] In the case of survivors of IPV, this could include fear of exercising autonomy due to concerns about further violence from the perpetrator, as in Tina's situation as she decided whether to live apart from Ray. The choice to live separately may not be straightforward. Older women are less likely to leave compared to younger people for a variety of reasons, including cultural expectations (eg, case 3) and fewer financial options.[7]

It is helpful to define the onset and temporal course of IPV, for example, long-standing IPV "grown old" vs new onset IPV later in life.[5] Chronic IPV can be insidious, and the survivor and other family members may have developed long-term mental health and physical issues as a result.[4,31] A history of coercive control is associated with increased risk of physical abuse in later years.[32] These could produce challenges to assessment and accessing help, especially as a survivor can feel isolated and increasingly dependent on their partner and perpetrator.[7] Physical and financial dependency and carer roles (case 3) are additional considerations. De novo IPV can be associated with onset of late-life illness, including mental illness (case 1) and cognitive disorders. The form of violence can shift with increased age to become more nonphysical (eg, emotional and economic).[6,33] However, new onset of violence may be associated with dementia.[5] Alongside the above-noted limitations in epidemiological research,[8,24,34] part of the difficulty with estimating the prevalence of types of abuse across the lifespan is that IPV is often conflated with elder abuse in older adults, rather than singling out the context of abuse by a romantic partner.[8] Thus, although particular risks are identified in the context of illness and disability, there is no clear pattern regarding changes in IPV across the lifespan.

Diagnoses Associated With IPV Perpetration

Psychiatric comorbidity is associated with IPV, for both perpetrators[35] and survivors,[4,6,36] and should be considered in an assessment of IPV. George's case highlighted delusional jealousy, which may be associated with perpetration of aggression,[5] including homicide.[37] Delusional jealousy may occur in various psychiatric conditions such as delusional and other psychotic disorders, mood disorders, certain neurological conditions,[38] and dementia.[39]

Rates of depression and anxiety are increased in survivors,[40] as in case 3. Substance use disorders are frequently comorbid for perpetrators and survivors.[41,42] Alcohol misuse has been associated with violence perpetrated by older adults,[36,43] including homicide in people with dementia.[37,44]

Certain personality traits are observed more frequently in general population studies of IPV perpetrators, specifically antisocial, narcissistic, histrionic, and obsessive-compulsive and borderline traits.[45] Ray's narcissistic personality traits conferred a particular type of vulnerability and response to "narcissistic injury,"[46] intersecting with his loss of role, social standing, and shame. Narcissistic injury can result from perceived threats to self-image and trigger a range of responses that can be aggressive or defensive in efforts to maintain self-worth.

Cognitive Impairment and IPV

Cognitive impairment, especially executive dysfunction, is associated with aggression in general and in perpetrators of IPV,[47,48] including in late life.[33] Dementia may be associated with homicide when there is disinhibition, for example, through executive dysfunction or alcohol use[44] but also related to impaired information processing and reduced cognitive flexibility to modify behavior following environmental stressors.[49] It is not just cognitive impairment per se, but the associated functional changes that are relevant in the assessment of risk in IPV in older adults. Agatha's case is an example of IPV "grown old," which highlights a change in the dynamic of the marital relationship over time. As her husband developed dementia, she became his carer. His changed behaviors, such as emotional lability and irritability, interacted with his dependence on her for ADL support. This exposed Agatha to greater risk given her physical proximity to him; the caregiver role recognized as conferring vulnerability.[4,5,50] She was in a difficult position as his wife, with recognized challenges[51] stemming from expectations of her carer role and culturally, despite his aggression. An objective assessment of his ADL function helped determine eligibility for external services, relieving her of aspects of his care.

Management

The cases illustrate the breadth of issues to be managed in older adults presenting with IPV. Addressing the immediate safety of older adults in a relationship is the first step. An assessment of risk and protective factors may be guided by a relevant risk assessment framework (these may need adaptation and combination with clinical judgment). There are useful structured guides for evaluating risk. The Spousal Assault Risk Assessment[52] has 24 items; 8 describe the nature of IPV, 10 code the perpetrator's social, psychological and interpersonal issues, and 6 describe vulnerabilities that may affect a victim's motivation, ability or opportunity to engage in self-protective behavior. It is not a decision-making tool rating risk, but a guide to collecting information relevant to decision-making. The DVSAT[14] is a checklist with two parts: (A) risk identification (25 items covering violence toward the client, the relationship between the client and partner, the partner's background, children, and sexual assault) and (B) professional judgment. The number of indicators present from Part A determines the level of threat, with nonspecified immediate actions suggested for serious threat. The Common Risk Assessment Tool[53] differs from the other two measures as it includes an analysis section drawing together identified evidence based risk factors, clinical judgment, and the victim's own perception of their level of risk. It has a dedicated section for responding to the level of risk with specific interventions listed. Identification of these factors may guide action on modifiable risks and where protective factors can be enhanced; see cases 1 and 2. Early practical decisions such as the setting of care are closely linked to risk assessment.

Thereafter, initial clinical management is informed by MDT assessment to assess issues underlying the IPV (Table 2). Comprehensive assessment and tailored interventions may be needed for both survivor and perpetrator, as in case 3. Underlying physical, mental health and cognitive disorders should be treated and explicitly discussed with the older person and their family, including how to seek help during periods of exacerbation.

Although not older-adult specific, guidelines are available to assist clinicians in managing survivors of family violence. For example, in Australia, the National Risk Assessment Principles for family and DV[28] outline an integrated approach to assessing violence relevant to survivors, perpetrators and children. Similarly, there are all-age resources for safety planning and education of survivors of family violence (Table 3). The Thriving Communities Partnership has a website outlining programs to support people in situations of family violence.[54] Phone apps may be useful, for example, Penda contains legal and other resources for survivors of DV and has tech features to promote safety (Table 3), although sensory impairment and disparities in digital skills[55] may limit older adults' access. International resources include the WHO compilation of studies of IPV response strategies targeting health care providers (clinical and policy guidelines)[56] and "RESPECT Women", a framework for preventing violence against women by educating the community about what respect means and how it is demonstrated and intervention recommendations.[57]

A fundamental consideration when managing IPV is the legal framework of care, including whether the jurisdictional Mental Health Act and/or Guardianship Act applies to both acute and long-term management (Table 1); for example, use of CTOs (cases 1 and 2) to improve medication adherence and reduce relapse risk. The jurisdictional Guardianship Act might be relevant in

Table 3.

Australian and International Resources for Safety Planning and Education[66–74]

Australian	International
1800RESPECT—National sexual assault, family, and domestic violence counseling line (phone and online services) Family Violence Law Help via National Legal Aid (www.familyviolencelaw.gov.au) National Family Violence Prevention Legal Services—Legal supports for Aboriginal and Torres Strait Islander people (www.nationalfvpls.org) Elder Abuse Help Line (1800 353 374)—Information, support, and referral options, including for abuse due to IPV Lifeline (13 11 44)—Crisis support/suicide prevention Phone apps: • Penda—Information for survivors of domestic violence on the law, safety, education, financial, well-being, and crisis numbers • Sunny—For women with a disability (includes various accessibility features)	Global: • "No More" Global Directory—A comprehensive international directory of support services and resources of DV helplines (www.nomoredirectory.org) • United Nations Women—Dedicated to gender equality and empowering women, this website includes information on relationship abuse, frequently asked questions, and helplines (https://www.unwomen.org/en) United States: • Prevent IPV—Provides a range of resources, tools, and training in the prevention of IPV targeting national/state/territory domestic violence coalitions and community based domestic violence programs (www.preventipv.org) • National Resource Center on Domestic Violence—Resources and training in preventing domestic violence across sectors (eg, individuals, community, health care providers, housing) • (www.nrcdv.org) • National Domestic Violence Hotline on 1800 799 SAFE (7233) (www.thehotline.org) United Kingdom: 24-hour national domestic abuse helpline on 0808 2000 247 (www.nationaldahelpline.org.uk) New Zealand: Shine domestic abuse services helpline on 0508 744 633 (www.2shine.org.nz/get-help/helpline)

Abbreviations: DV=domestic violence, IPV=intimate partner violence.

IPV involving older adults with dementia where the impairments impact safety. Application of Guardianship legislation may include provision of safer living arrangements and financial orders (to prevent abuse). Another consideration is international case law precedent regarding the duty to warn intended targets of violence.[58] Despite comparisons between vulnerable older adults and children with respect to identification and protection from abuse,[59] mandatory reporting laws for older adult IPV are not uniform in Australia. Similarly, coercive control laws vary across jurisdictions.[60] Notably, the United Kingdom has criminalized coercive control, as has Ireland.[61,62]

Finally, clinicians must consider sociocultural factors that influence responses to IPV, including cultural norms, gender roles within older-adult couples, and issues of discrimination against older adults.[63,64] In a study exploring the reasons why older women stayed in abusive relationships, the barriers to seeking support included fears of stigma, perceiving the abuse as "normal" or strong beliefs in societal norms that promote staying with a frail or sick perpetrator.[6,34] Case 3 highlights cultural expectations to continue supporting a spouse perpetrator.

Study Limitations

Generalizability of these findings to other settings and geographical locations may be limited given the small case series within one metropolitan area of Australia. A broader cohort of older adults with IPV (perpetrators and survivors) including people with more severe cognitive and functional impairment, cases managed under guardianship legislation, male survivors of IPV, diversity of sexual orientation,[9] and broader cultural backgrounds would be informative. All cases presented were of male perpetrators of IPV, reflective of clinical practice and the literature.[8] Longitudinal follow-up data were limited although may have been valuable to elaborate aspects of long-term management and outcomes of IPV in older adults.

CONCLUSION

This case series highlights the complexity in assessing and managing IPV in older adults in a mental health service, including relevant clinical and practical factors, ethical issues, legal and sociocultural considerations, and dignity of risk.[65] Further qualitative and quantitative research (eg, prevalence studies) examining IPV in older adults specifically is needed to inform the development of older adult-specific IPV services. This should be matched with increased community education and awareness campaigns, including clear pathways for support and intervention.

Article Information

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