


**Instructions to CE enrollees:**

The closed-book, multiple-choice examination that follows this article is designed to test your understanding of the educational objectives listed below. The answer form is on page 195.

**On completion of this article, the reader should be able to:**

1. Discuss issues related to long-standing wife abuse
2. Identify behaviors seen in the abuse of aging caregivers
3. Describe assessment techniques and interventions for aging women

# Domestic Violence and Aging Women



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**Abstract:** Domestic violence against women is a significant health problem in this country and worldwide. A group that has been neglected, however, in discussions of this problem are older women. Although one might assume that domestic violence against older women is included in discussions of elder abuse, that body of literature actually may obscure the problem for several reasons. This article discusses the background of domestic violence against older women in two contexts: long-standing wife abuse and abuse of aging caregivers. Suggestions for assessment and intervention are included. (*Geriatr Nurs* 2000;21:188-93)

**D**omestic violence affects women in all age groups, but most literature focuses on the problem as it affects women in the child-bearing/child-rearing years. Often ignored are the special problems of aging women as victims of domestic violence. The purpose of this article is to discuss domestic violence as it affects aging women within two contexts. First, domestic violence will be viewed from the perspective of wife abuse because some older women whom health professionals encounter are long-standing victims; the problem is nothing less than wife abuse "grown old." Second, domestic violence will be

viewed as it occurs in the context of caregiving. Aging women provide care to aging spouses and partners, parents, siblings, and disabled children. Although the two contexts obviously are not mutually exclusive, particular issues are raised within the caregiving context that deserve special attention.

## BACKGROUND AND OVERVIEW

Finding information in the literature about older women as victims of domestic violence is very difficult. The problems of this population actually are obscured by the literature base for several reasons. First, the terms *elder abuse* and *elder mistreat-*

ment are gender-neutral, which obscures the fact that two-thirds of the victims reported nationally are women.<sup>1</sup> Second, these terms focus attention on age as a critical attribute of the phenomenon and are used for a wide range of behaviors, including abuse, neglect, financial exploitation, and self-neglect. These two factors conceptualize the problem as rooted in a specific context for the victim: vulnerability and dependence. This characterization obscures the facts that vulnerability and dependence are not essential features of the domestic violence that affects older women and that many older women who are not dependent are victims.

The third reason the elder abuse/elder mistreatment literature actually obscures the problem of domestic violence against older women relates to its focus on the "caring" aspects of elder abuse, which fixes attention on a wide variety of perpetrators and the phenomenon as being rooted in an "inadequate care paradigm" rather than the family violence paradigm. Several years ago, I argued for just that position.<sup>2,3</sup> On one hand, important clinical value lies in viewing elder abuse/elder mistreatment from an inadequate care perspective. It permits clinicians greater latitude in identifying dependent elders who might need intervention and offers ideas outside of the criminal justice system.

On the other hand, this perception obscures several important facts. First, while some forms of elder abuse/elder mistreatment, most particularly neglect, are reflections of inadequate care and rooted in the dynamics of caregiving, some other forms of elder abuse/elder mistreatment, especially physical assaults, are domestic violence. Second, it obscures the gender issues and power dynamics inherent in domestic violence as they apply to older women. Data show that, even in old age, victims of physical abuse most commonly are women and perpetrators most commonly are men.<sup>4</sup>

Although problems with the literature make our understandings of domestic violence among older women incomplete, drawing from the literature and the research experiences of our team<sup>2,5,6</sup> it is possible to begin to outline some of the issues involved. The next sections will consider separately the two interrelated contexts within which domestic violence affects older women.

#### WIFE ABUSE IN OLDER YEARS

Some excellent case studies<sup>7-9</sup> provide voice to victims to illustrate the nature of the problems experienced, their effects on victims, and the life-long suffering that can be involved. These case studies provide striking evidence of the long-standing physical, sexual, and emotional abuse older wives can experience from life-long partners, as well as underscore the important

problem of economics as it influences older women's decisions about their options for living violence-free.

Harris<sup>10</sup> studied whether the factors related to couple violence in young families apply to couples 60 years and older. To answer this question, she reanalyzed Strauss and Gelles' data from the National Family Violence Resurvey and concluded that couple violence in the over-60 group was related to lower education levels of the husband (not the wife), ethnicity to the extent that African Americans and Hispanics were overrepresented in the violence group, higher levels of couple disagreement, higher use of verbal aggression, and higher perceived stress. Although the relationship of alcohol and drug use with wife abuse is strong in younger couples, that trend was not true for older couples. However, even in the over-60 group, at least one-fourth of the respondents associated the last occurrence of violence in their relationship to heavy or binge drinking. The long-standing nature of wife abuse was illustrated in these data by the fact that more than half of the 60-plus individuals reported violence that had begun more than 10 years before, and 40% said the first incident of violence had occurred more than 25 years before the interview.

A few qualitative studies have explored the phenomenon of wife abuse as experienced by older women. For example, Grunfeld et al.'s<sup>9</sup> study of life narratives collected from four English-speaking working-class women ranging in age from 63 to 73 identified 11 themes, including marriage license as a hitting license, a theme that underscored the importance of long-standing violence in marriages; violence in the family of origin; powerlessness; women being treated as objects; survival; and barriers to leaving. Many women linked their memories of domestic violence to aspects of their children's lives. Our own unpublished data<sup>6</sup> of in-depth interviews with 10 abused wives older than 50 contain some of these same themes. Also found in our data are the intense pressures created by children to stay in abusive relationships. Like Grunfeld, Larsson, MacKay, and Hotch, our data show children create implicit pressure that is stimulated by the guilt the woman feels when she envisions her children being raised without a father. In our study, however, some children created explicit pressure by begging their mothers to return once they had escaped and pleading with them not to leave.

Also noteworthy with regard to wife abuse in old age is the recent interest in homicide involving older wives. Although no studies of this phenomenon have been published, Donna Cohen, director of the Institute of Aging at the University of South Florida, has compiled data<sup>11</sup> that show an increasing number of older women are murdered by their husbands. Three patterns appear to be reflected. First, some of these homicides involve what appear to be murder-suicide pacts

prompted by the ill health of both partners. Second, some may involve unilateral decisions by a caregiving husband that his wife has “had enough.” Last, some seem to be the result of long-standing animosity on the part of the husband who finally acts on his feelings in old age or when his wife asks for a divorce. An interesting feature of this report is that there does not appear to be a corollary with increasingly more older women murdering their husbands.

What can be drawn from the literature to inform nurses about wife abuse among aging women? First and foremost, the literature is clear that wife abuse involving older women exists. Serious physical and emotional harm and even death can result from wife abuse at any age, but among older women, because of the physical vulnerability that arises with age (eg, greater risk for falls) even so-called “low-severity violence” (eg, pushing, shoving, and grabbing as opposed to hitting, slapping, or kicking)<sup>12</sup> can cause serious injury. In addition, with older women, wife abuse can be associated with lifelong suffering.

Second, much of the wife abuse literature focuses on abuse within long-standing marriages because these kinds of unions are the norm in this age group. However, wife abuse in the older years can arise in new marriages that occur among aging couples. In some ways, new marriages may even constitute special risk for older women, although this has not been studied. The reasons this suspicion might be true relate to the fact that all new relationships are characterized by a certain amount of turbulence as the couple learns to live together. Furthermore, as some of our data show, new marriages among older couples can be complicated by conflicts among grown children or the use and distribution of assets and resources from previous marriages, and new marriages between elders often escalate quickly into stressful caregiving situations.

The literature on older wife abuse informs nurses the problem is very complicated and hidden. Wife abuse in the older years can be complicated by factors that may not apply so strongly to younger women. In the United States, the women’s movement reached its height in the 1970s and had profoundly affected women’s views of themselves and their marriages, their likelihood of leaving unsatisfying or long-term abusive relationships, and their likelihood of recognizing themselves as abused.

For the most part, older women in this country are a breed apart from younger women. They are much more likely to have a “death-do-us-part” philosophy about marriage and a more “self-sacrificing” view of their own lives.<sup>13</sup> They are much more likely to accept behaviors in their spouses as “normal” that younger women might term as abuse. In addition, abuse of older women is more hidden. Unlike younger women, older victims are not reflected in the media<sup>7</sup> and rarely

are represented in battered women’s shelters and other services for battered women.<sup>13</sup> They have no natural “gathering” places outside of churches, which can have their own sanctions against leaving even abusive marriages.

Compared with younger women, older wives are less likely to be employed or have regular contacts outside of their homes that might offer the opportunities for them to find others in similar situations with whom they might identify and receive support. For a variety of reasons, not the least of which is the financial ruin that can occur to them as a result of being separated from their abuser, it is reasonable to assume that they are unlikely to admit they are being abused and, when asked, are likely to deny that abuse is occurring. The net result of these forces is that older wives may have more difficulty recognizing themselves as abused women and may see fewer options even if they believe they are abused.

#### DOMESTIC VIOLENCE WITHIN THE CONTEXT OF CAREGIVING

In 1996, our research team completed a study of 158 caregivers who were 55 or older and a wife/domestic partner or daughter/daughter surrogate of the dependent elder. Fifty (31.6%) caregivers reported they had been mistreated by the elder for whom they cared. While 50 women said they had been mistreated (using the Modified Conflict Tactics Scale<sup>14</sup>), 63 (39.9%) actually reported one or more types of mistreatment. The most frequently reported forms of abuse were:

- Elder yelled or swore at me (N = 44, 27.8%)
- Elder pushed, grabbed, or shoved me (N = 19, 12.0%)
- Elder threw something at me (N = 15, 9.5%)
- Elder verbally threatened me (N = 14, 8.9%)
- Elder slapped me (N = 10, 6.3%)
- Elder mistreated me some other way (N = 10, 6.3%)

Examples under “something else” included the caregiver being forced to have sex with the elder when she didn’t want to, being belittled by the elder, or accused of something (eg, stealing, infidelity). Six caregivers (3.8%) had been threatened by a weapon, and four (2.5%) actually had had a weapon used on them. In no situation had the police been called, but two (1.3%) women had sought medical treatment. When data were analyzed as to whether the caregiver was a wife or daughter, significantly more wives reported being yelled and sworn at, the elder had stolen or misused her assets, and one or more abuses. In addition, only wives had been threatened with weapons or had a weapon used against them.

Although this phenomenon has not been studied extensively, some researchers believe that caregiver abuse is related to the elder's cognitive status. However, our data show that caregiver abuse is not only a function of dementia. In fact, the association between cognitive status and caregiver abuse is quite weak. Abuse by elders may be thought to be a response to abusive caregiving by the caregiver, but our data show no relationship between elder abuse and caregiver abuse. Much of this abuse probably is a manifestation of long-standing wife abuse and, for daughters, at least some is a manifestation of previous child abuse that is reactivated within the intensive intimacy of the caregiving relationship. Qualitative data from our recent study clearly substantiates these assertions.<sup>6,15</sup>

#### IMPLICATIONS FOR GERONTOLOGIC NURSING PRACTICE

##### Assessment

Varvaro<sup>16</sup> reminds us that, based on the position statements of both the American Nurses Association<sup>17</sup> and the American Medical Association,<sup>18</sup> identification and assessment of women for domestic abuse is now the standard of care. Whether this standard has translated into the practice of most nurses as they are in contact with older women is not clear. Given the focus in the literature on domestic violence as a problem of only young women, there is reason to believe this is not the case. Therefore, the first question that needs to be answered is who should be assessed. That answer is simple. The possibility of domestic violence should be part of the initial assessment of every older woman, whether she is in the ED, an ambulatory care setting, or is receiving senior services (eg, adult day health, home health services, hospice, or services in nursing homes). Assessment shouldn't be reserved only for dependent elders.

Although injury may be a reason for an older woman to seek care, it is important to remember that the physical and mental sequela of domestic abuse are many, including depression, sleeplessness, chronic pain, atypical chest pain, and a myriad of other kinds of somatic symptoms.<sup>12,19,20</sup>

An excellent clinical assessment guide has been developed by Neufeld<sup>21</sup> based on a letter by Ashur<sup>22</sup> that appeared in *JAMA*. This guide contains the "SAFE" questions that focus on four areas: stress/safety, afraid/abuse; friends/family, and emergency plan. In our research, we have learned that using the word *abuse* with older women can be counterproductive. Much more effective for us has been asking about specific behaviors, such as, "Has \_\_\_ ever hit you?" or "Has \_\_\_ even threatened you?" Neufeld<sup>21</sup> suggests that asking, "What happens when you and \_\_\_ disagree?" is a strategy that might open the discussion to explore for abuse.

In situations involving abuse of a cognitively impaired or unresponsive elderly woman, assessing non-

verbal cues is important, as is focusing assessment on the caregiver. In our work, we have found that asking caregivers about their own abuse eventually can lead to revelations about their abuse of the elderly person. Stark and Flitcraft<sup>23</sup> identified some characteristics of batterers that might increase a health professional's index of suspicion in situations where the elderly woman cannot speak for herself. These include showing possessiveness and jealousy of the victim, denying or minimizing the seriousness of the violence, refusing to take responsibility for the violence, and holding a rigid view of a sex role or negative attitudes toward women. Negative attitudes toward elders in general or the competencies of elderly women (or this particular elderly woman) might be clues to explore further. Although a foolproof strategy for assessing for domestic violence among older women doesn't exist, including consideration of the possibility of abuse during assessments clearly is essential.

##### Intervention

As with domestic violence at any age, intervention with older women is rarely simple. What makes intervention for this population even more complicated, however, is institutionalized ageism that creates a blind eye to the problem either through lack of awareness, a tendency to blame victims, or reluctance to believe victims. Vinton<sup>24</sup> presents an eloquent description of the social factors that contribute to the oppression of older women. Some of the factors she identifies include the existence of popular images that portray older woman as ugly or absurd, lacking worth in a society that defines productivity in terms of workforce participation, and stereotypes of women that focus on incompetence and dependence.

Complicating intervention for domestic violence involving older women are the artificial boundaries that have been created in the service sector. Most shelters are not equipped to handle women with disabilities, and very few have separate programming targeting this group. This situation is very slowly changing.<sup>24,25</sup> Similarly, the protective service system designed for elders has no methods for dealing with domestic violence among older women who do not qualify under elder abuse laws. Because of these complications, effective intervention for domestic violence among aging women needs to have two prongs—individual-level and community-level involvement—and nurses have a role in both.

##### Individual-Level Intervention

The following are some tips that might assist the nurse dealing with older women to design individualized interventions

**Take the time to ask and listen.** Ignoring the problem makes it go away only for you. When the

woman goes back home, her situation will be unchanged. Asking and listening take time, so make it. These actions take courage because sometimes women tell you things that you simply would prefer not to know. Find the courage. Sometimes asking and listening result in being called on to do things we don't know how to do. Learn all you can and figure it out.

**Do not allow yourself or the woman to believe the situation is hopeless.** In our research, we sometimes have other health professionals tell us the families we work with are hopeless because they have tried everything, and the situation hasn't changed. Women change when they are able. Sometimes change occurs with the first contact, but in our experience with abused caregivers, that is rare. Most women have sought help many times from friends, pastors, other health professionals. Sometimes what they decide to do doesn't work for whatever reason; sometimes they decide not to do anything for whatever reason. However, the fact that a situation appears unchanged doesn't mean nothing about the situation has changed. Nor does it mean nothing ever will change. The domestic violence literature is very clear that sometimes women take years to decide what to do. Maybe this time will be *the* time.

**Help the woman find a word she is comfortable with to describe her experience and provide reflective feedback.** Although we might view the incident as abuse or assault or battering, some women may say the experience is "just the way he is" or it's just "his drinking" or "his dementia." Helping abused women find their own words is important, but equally important in this process is providing reflective feedback that it is not acceptable for a woman to be harmed, physically or emotionally, by another person.<sup>26</sup> In several case studies (eg, Grunfeld, Larsson, MacKay, Hotch<sup>9</sup>), the first step to change happened when someone helped the woman frame her experience in the context of what and what is not acceptable treatment from another person.

**Document the abuse.** Whether or not the woman ultimately decides to take action, nurses have a responsibility to document the woman's words about who abused her, what happened, and when it happened.<sup>26</sup> Descriptions of injuries need to be included in the record, including the size and location of bruises. Photographs of injuries can be taken with the woman's permission.<sup>27</sup>

**Offer concrete assistance in helping the women manage the situation.** For many complex reasons related to the options they see available and the roles they believe they must enact, most of the women we work with have no intention of leaving the abusive relationship. The intervention we use, which focuses on how to help them manage if they do not leave, is based on the prevention/educative model proposed by Campbell, Harris, and Lee<sup>28</sup> based on Haddon's<sup>29</sup> model of injury preven-

tion. The basic premise of this model is that injury needs to be conceptualized as having three phases: pre-event, event, and postevent. Our goal is to alter the relationship among host, agent, and environment to prevent the next episode of aggression. Therefore, education focuses on recognizing the factors that have given rise to the aggression to prevent future episodes.

We help the women analyze what has happened to them and look for patterns. We help them design concrete strategies for derailing the next incident. In addition, we provide them with education about anger control, communication, conflict management, and conflict containment;<sup>30</sup> nonabusive methods of interaction and strategies for managing the stress and burden associated with the caregiving role; and strategies for reducing isolation.<sup>31</sup> We also help them reframe their image of the elder and caregiving<sup>2</sup> and devise strategies for providing care that are nonconfrontational.<sup>32</sup>

In addition, we offer them opportunities to rehearse their approaches to the elders. We help them identify individuals in their social network who can provide them with help and have them role-play exactly how they will ask for help and what they will ask for. We help them develop a concrete safety plan that includes numbers to call and places they can go if the situation gets out of hand. Campbell<sup>33,34</sup> has excellent guidelines for assessing danger and developing a safety plan. We help them assess their progress. Initial tests of this intervention<sup>35</sup> suggest its effectiveness in reducing abusive behavior and negative emotions, such as caregiver depression, particularly for women providing care to abusive husbands.

**Describe services, make referrals, and offer to advocate.** Older women need to be given information about local shelters or domestic violence hot lines and police help and how to interact with the legal system to obtain a court order for protection or press charges for assault. Providing older women with this kind of information is very important. Just as important is being willing to advocate on her behalf if she wants support so she can act on her decisions. Sometimes the most basic support that can be provided is helping the woman decide whom she would like to call and rehearse what she would like to say on her own behalf.

#### Community-Level Intervention

Domestic violence not only involves interactions between people but also a society that implicitly and explicitly sanctions violence. Dealing with domestic violence must include attention to the community. The following tips are ways in which nurses might make a difference.

**Combat ageism and sexism in the workplace and in the community.** Stereotypes influence how aging women see themselves and may silence their voices about their experiences with domestic violence.

**Get involved in sharing expertise about aging with groups focusing on domestic violence.** Domestic violence workers need input about aging women, their problems and needs, and how aging affects the way they view their own situations. Nurses have very specialized knowledge that could make a tremendous difference in shaping services and the way they are provided.

**Provide testimony to public leaders about what you know.** Most nurses are wonderful storytellers. They have a wealth of personal experience that reflects the lives of the women they provide care to and usually can organize stories effectively to get the point across. The only problem with nurses' stories is that they usually are told among each other. One of the ways nurses can provide community-level intervention is to share stories with the people who count—politicians and policy-makers.

**Educate the public.** Public education can involve formal presentations and, probably more importantly, can occur on a person-to-person basis. Nurses can educate their own social groups, church groups, families, and friends about domestic violence and how it affects both young and old women. Domestic violence is sustained by its invisibility; one of the ways to stop it is to get the word out.

#### SOME FINAL THOUGHTS

Domestic violence is a significant health problem in this country. Although this issue affects young and old women, the former have advocates, and many younger women have learned to speak for themselves. This observation is not to say the problem has been solved for younger women but awareness of their problem is growing and some help is available. The situation of aging women is quite different. The problem is virtually unrecognized and resources virtually nonexistent. Bringing the problems of older abused women into the mainstream is one of our challenges for the future.

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1. What percentage of elder abuse/mistreated people are women?
  - A. 33%
  - B. 50%
  - C. 75%
  - D. 66%
2. The literature search for this topic is obscured by the following factors EXCEPT:
  - A. Elder abuse/mistreatment is gender neutral.
  - B. The incidence is so small that little is reported.
  - C. Vulnerability and dependence are not required features.
  - D. This problem is rooted in an inadequate care paradigm.
3. What characteristic was NOT listed as a factor in couple violence in the over-60 group?
  - A. Lower education level of husbands
  - B. Ethnicity overrepresenting African Americans and Hispanics
  - C. Total dependence on each other
  - D. Higher levels of disagreement and verbal aggression
4. What percentage of the over-60 domestic violence group identified a connection between their violence and heavy drinking?
  - A. 10%
  - B. 25%
  - C. 35%
  - D. 60%
5. When children are factored into an abusive relationship, which theme was NOT discussed?
  - A. Children being victims of abuse if the mother leaves
  - B. Pressure by children for the mother to stay in the abusive relationship
  - C. Guilt by the mother envisioning her children being raised without a father
  - D. Children begging the mother to return
6. "Low severity violence" can be described as any of the following EXCEPT:
  - A. Pushing
  - B. Grabbing
  - C. Kicking
  - D. Shoving
7. Even new marriages among older adults can experience abuse/mistreatment for the following issues EXCEPT:
  - A. Conflicts with grown children
  - B. Use and distribution of assets or resources
  - C. Quick escalation into a caregiving role
  - D. Personality conflicts and incompatible values
8. The women's movement of the 1970s has affected women's views of themselves in the following ways EXCEPT:
  - A. Views of their marriages
  - B. The likelihood of leaving an unsatisfying relationship
  - C. The need for a partner and society's expectations of a family unit
  - D. The likelihood of recognizing themselves as being abused
9. In cases where women were caregivers to an older man, what percentage reported they had been mistreated?
  - A. 10%
  - B. 25%
  - C. 32%
  - D. 44%
10. Of the female caregivers who reported being mistreated, 12% indicated the type of abuse was when the elder:
  - A. Swore or yelled
  - B. Pushed, grabbed, or shoved
  - C. Threw something
  - D. Verbally threatened
11. This study asserts that the greatest probability for abuse is related to the:
  - A. Elder's cognitive status
  - B. Abuse by the caregiver
  - C. Long-standing patterns of abuse
  - D. Elder's dementia
12. Who should be assessed for domestic violence?
  - A. All women
  - B. Only women presenting to the ED with physical complaints
  - C. Only women presenting to ambulatory care settings
  - D. Only women who indicate they have been abused
13. "SAFE" questions focus on which areas:
  - A. Seriousness, attacks, fearfulness, explosion
  - B. Stress/safety; afraid/abuse; friends/family; emergency plan
  - C. Support; altercation/attack; friends; escape plan
  - D. Stigma; afraid; financial; energy to leave
14. In situations with cognitively impaired or unresponsive elderly women, the caregiver may exhibit possible abusive behavior in the following characteristic manners EXCEPT:
  - A. Demonstrations of possessiveness and jealousy
  - B. Minimizing seriousness of the violence or injury
  - C. Negative attitudes toward women
  - D. Plausible description of patterns that led to the injury
15. Intervention for domestic violence should include:
  - A. An individual and community approach
  - B. Strict legislation with penalties for nonreporting
  - C. Methods to remove the abused person from the environment quickly
  - D. Harsher punishment for the abuser
16. When focusing on the individual level of intervention, attention should be given to the following EXCEPT:
  - A. Active listening
  - B. Feelings supporting hopelessness
  - C. Using a prevention/education model
  - D. Framing what is acceptable and what is not acceptable behavior

**CE ANSWER/ENROLLMENT FORM**

To receive continuing education credit for any test in this issue, simply do the following:

1. Read the article.
2. Take the test for the article and record your answers on the form below. (You may make copies of the answer form.) You should complete one answer form for EACH test.
3. Mail the completed answer/enrollment form along with a check or money order. Payment must be included for your examination to be processed.
4. The deadline for submitting your answer/enrollment form is 2 years from the date of this issue.
5. Your results will be sent within 4 weeks after your answer form is received. Enrollees who have a passing score will receive a certificate.

Instructions: Mark your answers clearly by placing an "x" in the box next to the correct answer.  
This is a standard form; use only the number of spaces required for the test you are taking.

Test I.D. No. \_\_\_\_\_

1. <input type="checkbox"/> A	2. <input type="checkbox"/> A	3. <input type="checkbox"/> A	4. <input type="checkbox"/> A	5. <input type="checkbox"/> A	6. <input type="checkbox"/> A	7. <input type="checkbox"/> A	8. <input type="checkbox"/> A	9. <input type="checkbox"/> A	10. <input type="checkbox"/> A
<input type="checkbox"/> B	<input type="checkbox"/> B	<input type="checkbox"/> B	<input type="checkbox"/> B	<input type="checkbox"/> B	<input type="checkbox"/> B	<input type="checkbox"/> B	<input type="checkbox"/> B	<input type="checkbox"/> B	<input type="checkbox"/> B
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Name \_\_\_\_\_ Credentials \_\_\_\_\_

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**PROGRAM EVALUATION**

	Strongly agree			Strongly Disagree
The objectives of the program were met.	1_	2_	3_	4_ 5_
The content was appropriate.	1_	2_	3_	4_ 5_
My expectations have been met.	1_	2_	3_	4_ 5_
This form of CE is worthwhile.	1_	2_	3_	4_ 5_
The level of difficulty of this test was:	1_	2_	3_	4_ 5_
	Easy			Difficult

How long did this program take to complete? \_\_\_\_\_ hours

- I have enclosed an additional \$10 for rush processing.
- I have enclosed an additional \$15 for foreign delivery.